

DOCUMENT RESUME

ED 197 531

EC 131 733

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 TITLE The Project Sunrise Model: A Home Based Parent Teaching Program Designed to Serve Handicapped Children Ages Birth to Six Living in Rural Areas of Montana. Revised Edition.
 INSTITUTION Eastern Montana Coll., Billings.
 SPONS AGENCY Bureau of Education for the Handicapped (DHEW/OE), Washington, D.C.
 PUB DATE Jun 80
 NOTE 362p.
 EDRS PRICE MF01/PC15 Plus Postage.
 DESCRIPTORS Delivery Systems: *Disabilities: *Home Programs: Home Visits: *Intervention: Paraprofessional Personnel: *Parent Education: *Parent Participation: *Preschool Education: Program Descriptions: Qualifications: Rural Education: Teaching Skills
 IDENTIFIERS Montana: *Project Sunrise

ABSTRACT

Project Sunrise, a home based parent training model, was designed to serve preschool handicapped children living in rural areas of Montana. Literature was reviewed on when to begin educational intervention, the results of early intervention, the types of intervention most effective, the positive effects of parent education, and the benefits of early intervention for handicapped children. The Project Sunrise model comprised four basic elements--the child, the parents, the home visitor, and the center staff. Project Sunrise services to children included identification, screening, a functional assessment of skill strengths and weaknesses, a diagnostic evaluation conducted by an interdisciplinary team, program planning, program implementation, and program reassessment. An important part of the assessment/evaluation process was the parents' role in collecting data as part of the Family Education Program. In addition to acting as primary or support teachers to their child, parents also assumed the roles of program support personnel, program advocates, and paraprofessional home visitors within the program. The paraprofessional home visitor served in a helping relationship as the teacher (educational change agent) and informal peer counselor to the parent. Home visitors must demonstrate competency in six areas: knowledge of the Project Sunrise model, identification and screening, assessment, planning and implementation of the Early Education Program, child program planning and implementation, and legal rights. Center staff consisted of the center aides (who confer weekly with the paraprofessional home visitors by phone), early childhood special education specialists, and the coordinator. Appended are Montana rules and regulations for special education, a list of published materials used in the development of the model, and materials from the home visitor training program. Sample evaluation instruments, forms, and charts are provided throughout the document. (SBH)

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THE PROJECT SUNRISE MODEL

A Home Based Parent Teaching Program Designed
To Serve Handicapped Children Ages Birth to Six
Living in Rural Areas of Montana

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Revised Edition

June, 1980

EC131733

This document was supported by a grant from the Bureau of Education for the Handicapped, Office of Education, U. S. Department of Health, Education and Welfare. Grantees undertaking such projects under governmental sponsorship are encouraged to express freely their judgment in professional, technical matters. Points of view or opinions do not, therefore, necessarily represent official Office of Education position or policy.

First Printing December, 1978

Second Printing June, 1980

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ABSTRACT

Project Sunrise is a home-based parent training model designed to serve preschool handicapped children living in rural areas of Montana. Children ages birth to six years exhibiting handicapping conditions or developmental delays are considered eligible for services. Educational activities are implemented daily by the parents who are trained in behavior modification techniques by a paraprofessional home visitor. The home visitors, in turn, are trained and supervised by early childhood special education specialists.

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PREFACE

Montana, The Big Sky Country

Montana is affectionately known as the Big Sky Country. Its wide open spaces and sparse population make it a highly popular vacation spot. It is, however, those same thousands of square miles of free space which present headaches in planning delivery of services to its 533 cities, towns and communities. Montana's 748,000 residents make up a state population which is only slightly larger than the population of Indianapolis, Indiana. However, instead of being confined to one large urban area, these residents are scattered throughout 147,138 square miles, an area that is almost four times the size of the state of Indiana. This means that the handicapped population is widely separated by large geographic distances. Especially in the sparsely populated areas of Eastern Montana, families live as far as fifty or more miles from the nearest services. Even then the county seat or nearest shopping area may not be large enough to support more than itinerant mental or public health services delivered monthly from a somewhat larger town located anywhere from fifty to a hundred miles away. Delivery of even itinerant services is often hampered by poor roads and inclement weather, which often isolates communities for several days at a time during the winter and spring. To deliver services to Montana's handicapped population usually requires ample funding for transportation costs, either for the recipients or for the

service delivery personnel.

Additional problems exist in meeting the needs of the pre-school handicapped population. Most of Montana's small rural towns and communities have no nursery school or day care facilities. Some parents have to transport their child several miles just to allow him or her opportunities to play with a child of the same age. As a result, parents may have no way to compare their young child's development to that of other children. A mildly handicapping condition, which might easily be remediated with early intervention, may go totally undetected.

Many Montana school districts have only six-week kindergarten programs in the spring. Some have no kindergarten programs at all. Public education then often begins at age six, and until that time the school system may have no knowledge of a child with a potentially handicapping condition.

Once a child reaches school age and such a condition is identified, it may be difficult to obtain an evaluation which can lead to appropriate programming. A system of regional special education services no longer exists under the sound organizational structure it had prior to the 1977 legislative session. From 1972 to 1977 the state was divided into five service areas for special education. Each area had a team assigned to it which was, upon request, responsible for providing evaluations and consultant special services to the school districts in its area. Presently

a school must either be a member of a special education cooperative or try to obtain services through the less well-defined regional services system, which is administered and controlled by a host school district. As a result many districts are, for all practical purposes, without services.

In addition, Montana House Bill 624 abolished the mandate of House Bill 816 which guaranteed services to identified handicapped children between the ages of three and twenty-one as of September 1, 1980, and made such services permissive. A very limited number of school districts have elected to provide varying degrees of services to handicapped children age birth to five years under H.B. 624. A unique set of problems are posed for districts providing preschool services. Few trained and certified teachers of "normal" preschoolers exist in the state. Almost no teachers have both early childhood and special education training.

It is a real advantage to the state that the Bureau of Education for the Handicapped (BEH) chose to fund a Handicapped Children's Early Education Program (HCEEP) grant within Montana. The grant awarded in August, 1977, was made to Eastern Montana College (EMC) at Billings to develop a model delivery system to provide for the needs of young handicapped children living in rural areas. It was for this purpose that Project Sunrise was developed.

Early Childhood Education For The Handicapped

To say that Western society is complex would certainly be a gross understatement. We can, however, only begin to look at the educational needs of our citizens when we first examine our culture and the world in which we must function. It is no longer sufficient that we be able to simply build a fire, design and use crude hunting instruments, and obtain shelter in the nearest cave. To say just exactly which skills we do need to function within a complex society becomes increasingly difficult. The rapidity with which our technology is advancing makes coping, even for the non-handicapped person, an arduous task. As Alvin Toffler (1970) said in Future Shock:

Unless we capture control of the accelerative thrust-- and there are a few signs yet that we will--tomorrow's individual will have to cope with even more hectic change than we do today. For education the lesson is clear: it's prime objective must be to increase the individual's "cope ability" -- the speed and economy with which he can adapt to continual change (p.403).

The burden placed upon our educational system to produce individuals capable of coping with a rapidly changing world is heavy. We cannot afford failures. Unfortunately, the human brain is exceedingly complex; very little is known about its structure. The process of learning is still understood only as a theory, and teaching techniques must be approached somewhat experimentally with each child.

In spite of the fact that much still remains unknown, our depth of information about how we learn is increasing yearly which provides us with some optimism. Two areas in which we have made considerable progress during the past couple of decades are in the fields of early childhood and special education. Admittedly, we have only begun to explore these vast areas and knowledge and research is still limited. We realize that new developments will keep our foundations shifting. As educators, we will need to remain flexible in order to accomodate progress in the field.

Still, it is imperative that we take what we now know and begin. We cannot postpone our involvement. Ideally we would like to know much more, but we cannot afford to wait until all of the evidence is in. We now know that for many children, particularly the severely handicapped, the formal educational process must begin early. Increasingly, research is showing us the value of early intervention programs. It is imperative, that, as a society, we respond now, realizing that we are moving without answers to all of the questions which we are asking. It is with this knowledge (or lack thereof) and with a firm commitment to strive to do what is best for the child and his or her family that the following model for serving preschool handicapped children is proposed.

Chapter 1

EARLY INTERVENTION

In looking at the young handicapped child it is paramount that society realizes, regardless of the nature or the severity of the handicap, that the child is first a child -- an individual with needs similar to that of any other person. Of lesser importance is the fact that a handicapping condition is present which in some way changes the child's ability to perform or to respond to his world. It is for this reason that educators must examine both what is known about early childhood education and what is known about special education. Educators have a responsibility not only to the child who is taught but also to the taxpayers as well to assure that what is done is effective. William Yule has written, "Responsibility implies always asking whether one is justified in intervening, and considering what value the goal has for both the individual and society."

For this reason educators must first ask, "What is the value of early intervention for any child, but particularly for the handicapped child? Is early intervention necessary? Is it effective? If so, for what kinds of intervention should we strive?"

How Soon Should Intervention Begin?

It is important to determine when educational intervention is appropriate. In order to do that it is necessary to examine what is known about early childhood development in the normal child and

the result of research for disadvantaged children. The "disadvantaged child" generally refers to one whose home and environment are unable to supply the kinds of richly stimulating experiences needed for normal development. Commonly, programs focusing on the disadvantaged child have been implemented in low-income urban areas where large numbers of families live under poverty conditions. Studies conducted in these areas have resulted in a continuing controversy regarding the nature (genetics) versus nurture (environment) and its affect on development. The nature-nurture controversy still remain only partially answered, and it is still unknown just how great a role genetics and environment each play in the development of the intellect.

It is now widely recognized that the first few years of a child's life are instrumental in helping the child reach his potential. A number of researchers now believe that as much as 80 per cent of the intellect is formed before a child goes to school (Bell, 1972; Bloom, 1964; Schaefer, 1970; White, 1975). Although this premise continues to generate considerable doubt in the minds of other leaders in the field, the child's environment is widely recognized as an influential factor in determining his or her ability to succeed in school. Bloom (1964) studied environmental effects as they influence later intelligence. He concluded that half of the variation seen in adult intelligence is evident by age four, and that development which was lost in one period could never be fully recovered in another. J. McVicker Hunt's (1961)

analysis of the theory and research in the field led him to conclude that deficits in functioning resulted from early deprivation and that, conversely, gains should be expected from early stimulation. It was, in part, from this research that the rationale for "compensatory education" (organized educational programs to provide the disadvantaged child with experiences and opportunities which his home and environment could not supply) was developed. From this rationale came the conception and implementation of Head Start programs in the 1960s and an increase in state funding for kindergarten programs.

To initiate educational efforts at ages four or five may be far too late to have the greatest impact. White and Watts (1973) stated the issues when they wrote:

Much of the child's crucial development was over by the age of six. By that age, so it seemed, it might already be too late to prevent stunted development and insure full growth.

Research conducted in the 70s indicates that education should, in fact, begin in infancy. Burton L. White, (1975), Project Director of Harvard University's Preschool Project and an early childhood researcher for nearly two decades, writes:

After 17 years of research on how human beings acquire abilities, I have become convinced that it is the first three years of life that we should now turn most of our attention. My own studies, as well as the work of many others, have clearly indicated that the experiences of those first years are far more important than we had previously thought. In their simple everyday activities infants and toddlers form the foundations of all later development (p.xi).

He goes on to say:

We have come to the conclusion that to begin to look at a child's educational development when he is two years of age is already much too late, particularly in the area of social skills and attitudes (p.108).

The question of how early to begin a child's education should not overlook prenatal, perinatal and neonatal health care needs. Preventive measures may be one of the most efficient ways of reducing the cost of special education. By providing good health care to teenagers nearing their reproductive years and to young mothers during the prenatal months, birth defects which now contribute to the special education population might be sharply reduced and/or eliminated.

In addition, medically screening of the new born would potentially reduce many of the handicaps which now require year after year of special education intervention -- if not institutionalization. A cost-benefit analysis of a screening program designed to identify metabolic disorders in newborns was conducted by the Massachusetts Department of Health in 1972-73 (Massachusetts Medical Society, 1974). They computed the cost of conducting a complete screening of all newborns in Massachusetts for the presence of metabolic disorders that would result in mental retardation. Seven children were identified as having disorders that, without medical intervention, would have resulted in mental retardation. They then compared the cost of screening to the projected costs for twenty years of institutionalization for those five children

whom it was believed would have required it. That one-year screening program is estimated to have saved the state of Massachusetts over \$365,000, and the savings do not reflect the cost of special education for the remaining two children. Regretably, due to the immediate expense, the screening program was not refunded.

This study is not included as a rationale for beginning early intervention during the prenatal period. It is, however, presented as cause for members of the human services professions to begin to look seriously at interdisciplinary support. Education does not exist in a vacuum. Serious educators need to look at other professions for answers and to lend support to those programs that can help to reduce the need for extensive and expensive educational intervention.

How early is early enough? still remains a question to be answered. Some leaders in the field believe that educators need to assume at least some responsibility for a child's development from birth (White, 1975). More and more programs are being developed to serve infants, especially those who are handicapped. At least for the disadvantaged, low-income child, the Developmental Continuity Consortium concluded, "there is now no indication of a 'magic age' at which early intervention is most effective" (p.108).

Does Early Intervention Produce Results?

If early intervention is to begin at an early age, what kinds of intervention are effective? How can effectiveness be measured? Admitted, the research is sketchy since there are only about fifteen

years of early childhood research upon which the findings can be based. Programs begun in the '60s are only now beginning to provide answers about effectiveness. Still the trends seem clear.

The first question which needs to be answered, especially in the eyes of public policy makers, is, "Are early childhood programs productive?" The final chapter has not yet been written in answer to this question, however, based on the most current studies available, the answer is, "Yes, good early childhood programs are effective."

In an intensive analysis of 14 early childhood programs implemented in the 1960s and early 1979s, a study sponsored by the Education Commission of the States and the Office of Human Development Services of the Department of Health, Education and Welfare found that:

- 1) Early education significantly reduced the number of children assigned to special education classes,
- 2) Early education reduced the number of students held back one or more grades, and
- 3) The children from all three types of programs (home-based, center-based, and combination home-center-based) surpassed their controls for up to three years after the end of the program on the Stanford-Binet. This significant difference appears to last through the primary grade (Lazar, et al., 1977, p. 13).

The fact that early education significantly reduced the number of children assigned to special education classes has important implications in terms of reduced educational costs. Of course,

criteria for special education placement varies from school to school. However, four out of five programs, which compared program children to closely matched control children, found significantly fewer special education placements among the program children. The indication is that program effects improved school performance. If early educational programs can prevent the necessity of special education placement for a substantial number of children, those efforts may pay for themselves in the eyes of the taxpayer -- to say nothing of advantages to the child and his or her family in terms of avoiding the stigmatism and labeling process so often associated with special education.

Early education was also found to reduce the number of students retained in one or more grades. Once again, it must be realized that criteria for retention vary widely from teacher to teacher. The trend across all programs, however, indicated five out of seven were able to reduce the number of children retained. Of particular significance was a project reported by Moore (1978) which included an especially high percentage of high-risk, Spanish-surnamed children. These program children were compared with a randomly selected sample of Spanish surnamed children in the general school population. Only 32.8 per cent of the program children were retained as opposed to 62.9 per cent of the general population for Spanish surnamed children.

For every additional year a child spends within the public

school system, that is an additional year of schooling for which the taxpayer must pay. Reducing the number of years it takes for a child to complete the educational process results in cost benefits. It would be difficult, if not impossible, to place a price tag upon individual benefits incurred from preventing school failure and grade retention. Certainly, however, in many cases it is difficult for a child to maintain his dignity and to believe in his own potential after experiencing repeated failure.

Although the value of intelligence tests is certainly open to question, the fact that children enrolled in early childhood programs made substantial gains which were maintained, even as long as five years after the termination of the intervention, is significant (Lazar, 1977). Although intelligence tests, such as the Stanford-Binet, are not designed to be a measure of school success nor of productivity in adulthood, it would seem that the better equipped children come to the educational experience, the more they would benefit from it. If the educational experience in turn is meaningful, children should be better able to approach the responsibilities of adulthood. If this is, in fact, the case and those children are then able to make significant contributions to their world (even if that is only measured by employment vs. unemployment), the extra effort invested in early childhood education could be thought to produce benefits throughout society as a whole.

In addition to the measures of school success, the Developmental Continuity Consortium conducted Parent and Youth Interviews

with programs and controls during 1976-77 when the subjects were nine to 18 years of age. When asked, "What is the worst trouble you've been in?" 20 per cent of the controls and 14.9 per cent of the program children mentioned police related incidents, drugs, thefts or being expelled or suspended. If early intervention programs are found in subsequent follow-up studies to reduce juvenile crime by approximately five percent, that would also represent a substantial savings to the public. During the interview children were also found to have higher job aspirations. They were also less likely to drop out of school, and when they did drop out, it was at a later age. They also rated how they were doing in school as higher than control children. Parent interviews revealed that parents in all programs were highly satisfied with the experiences and opportunities which the early childhood programs had afforded their children.

The conclusion of the report by the Consortium was:

The most important finding is that low income children who received early education are better able to meet the minimal requirements of their schools as shown in reduced rate of assignment to special education and in grade retention. In addition, the preschool programs improve cognitive skills into the primary grades as measured by the Stanford-Binet. Parental satisfaction with the programs was high as measured on the follow-up interviews. Preliminary analyses indicate significant differences in attitudinal responses such as program children rating themselves better than others in their school work as compared to their controls (p. 13-14).

What Makes Early Intervention Effective?

What types of intervention are most effective? Before answering this question, educators must first deal with how to define effectiveness. Researchers such as the Developmental Continuity Consortium (Lazar, 1977) and independent researchers such as Goodson & Hess (1976) believe that cognitive gains are one measure by which a program can be judged. This is one of the few means we have of making inter-program comparisons. Few other measures have been standardized in such a way that cross-program comparisons can be made.

This is not to say that other measures would not also be valid. The very fact that the Consortium incorporated the Youth and Parent Interviews and looked at various measures of school success indicates their recognition of important variables not reflected in intelligence tests. It is, however, extremely difficult to measure such variables as children's socioemotional growth, changes in self-concepts, and increased willingness to risk or trust. Many early childhood educators have believed that these were advantages to early intervention programs. Measurement techniques, however, are still too crude to accurately assess these benefits. For this reason, judgments about effectiveness will, by necessity, have to be made on the basis of more widely accepted criteria, such as intelligence and achievement test scores.

Urie Bronfenbrenner (1974), in a major report published by the Office of Human Development, summarized the elements that appear essential for early intervention programs to be effective. They are:

- 1) The evidence indicates that the family is the most effective and economical system for fostering and sustaining the development of the child. The evidence indicates further that the involvement of the child's family as an active participant is critical to the success of any intervention program. Without such family involvement, any effects of intervention, at least in the cognitive sphere, appear to erode fairly rapidly once the program ends. In contrast, the involvement of the parents as partners in the enterprise provides an on-going system which can reinforce the effects of the program while it is in operation, and helps to sustain them after the program ends.
- 2) The first and most essential requirement is to provide those conditions which are necessary for life and for the family to function as a child rearing system. These include adequate health care, nutrition, housing, employment, and opportunity and status for parenthood. These are precisely the conditions which are absent for millions of disadvantaged families in our country.
- 3) A long range intervention program may be viewed in terms of five stages. Although the program may begin with benefit to the child at any age, initiating appropriate intervention at earlier stages can be expected to yield cumulative gain. Ideally intervention should not be interrupted (for then the gains achieved are gradually eroded) and there should be continuity from one phase to the next. During every stage the first requirement is to meet the family's basic needs as outlined above. Thereafter, intervention is differentiated to accommodate the developmental level of both family and child as indicated below. (p.55)

The stages of intervention to which Bronfenbrenner refers are:

- Stage I - Preparation for Parenthood
- Stage II - Before Children Come
- Stage III - The First Three Years of Life
- Stage IV - Ages Four through Six
- Stage V - Ages Six through Twelve (pp.55-56).

Beginning with Stage III, Bronfenbrenner urges the intense involvement of the parents in the development of the child. He recommends frequent home visits during Stage III which encourage "sustained patterns of verbal interaction around tasks which increase in cognitive complexity." (p.56). During Stage IV he recommends a cognitively-oriented preschool curriculum with a strong parent intervention program "to enhance and sustain the effects of the group experience" (p. 56). Parent involvement throughout the school years is urged. In short, his report underlined the urgent need to begin to see parents as part of the educational team from infancy.

Goodson and Hess (1975) examined and summarized information regarding 28 contemporary programs who viewed parents as teachers of their own children. They looked at parent involvement as being characterized by four components. These components were:

- 1) parents as policy makers.
- 2) parents as more effective teachers of their own children,
- 3) parents as supporting resources for the school, and
- 4) parents as better parents.

Features of the programs which were found to produce the highest degree of effectiveness were:

- 1) the use of home visits either alone or in combination with preschool classes for children,
- 2) program content which required the active involvement of parents,
- 3) one-to-one parent teacher relationship, and
- 4) the use of a series of predetermined concrete tasks.

In another study on the factors which determine the effectiveness of parent education programs, Joseph H. Stevens, Jr. (1978) found that "effective programs have more readily achieved a balance between prescriptiveness and personalization" (p.59). He means that programs which personalized and modified the content of what they taught in order to meet the needs of each parent-child dyad produced greater effectiveness. He emphasizes that the parent consultants need to work from objectives which are clearly specified. Activities need to be carefully planned to meet these objectives. The activities need to be implemented with considerable consistency, "reflecting an attempt at quality control rather than rigidity" (p.59). He also believes that intervention for a minimum period of 18 to 24 months is necessary in order to provide input for the increasing competencies of both parent and child.

What Are the Positive Effects of Parent Education?

To simply plunge head-long into massive parent education programs because we need to "get parents involved" would be unwise. Educators must know first what objectives can be accomplished with parents and how to best accomplish those objectives.

What changes in parent attitudes and behavior might be expected from an effective parent education program? Goodson and Hess (1975) looked at both parent attitudes and parent-child interaction patterns. Significant changes in parent attitudes most often reported were:

A sense of personal control over their lives and changes in the parents' attitudes toward their children and their development.

The studies they examined found no significant correlation between parent attitudes and children's performance. They also warn, however, "the fact that attitudes are not clearly related to performance does not mean that attitudes do not affect behavior -- their influence may be more subtle than the available measuring instruments can detect" (p. 229).

Goodson and Hess also examined outcomes in terms of parent-child interaction by looking at measures of verbal and non-verbal behavior. Of six programs that assessed parents' language behavior in parent-child teaching situations, all found positive changes in at least one aspect of language. On measures of non-verbal behavior, three programs reported increased levels of social responsiveness on the part of the parents toward the child. This is

significant since both Gordon, Dunaugh and Jester (1972) and the Ypsilanti Infant Education Project (Weikert, 1973) found that parent behaviors correlated significantly with the intellectual functioning of children.

In a review of the literature, Stevens (1978) examined a number of parent education programs and found that they produced significant changes in parent behaviors. These included maternal teaching styles and attitudes. Mothers were found to use syntactically more complex language and more task appropriate language. They were also more likely to encourage the development of verbal skills in their child. These mothers demonstrated greater awareness of their child's characteristics, were more responsive to their child, and more willing to engage in reciprocal, cooperative play. They were better able to prepare an optimal home learning environment and provided more appropriate play material for their child. In addition they were better able to use household routine to further their child's learning.

SUMMARY

To summarize, research from early intervention programs for young disadvantaged children clearly points to the need for effective programming. It would appear that intervention should begin early in infancy, probably before age two, to be most effective. In addition, educators should support programs that would help to

reduce the incidence of handicapping conditions within the general population, such a good prenatal care and screenings for newborns to detect metabolic disorders.

Intervention which was begun early has been shown to reduce the number of children assigned to special education classes, to reduce in-grade retentions, and to increase standardized intelligence test scores. Other less well-substantiated benefits include reducing juvenile crime and school drop out rates. In short, early education produced better "cope-ability" for students when formal education actually began.

The effectiveness of early intervention is clearly tied to the involvement of the family in the educational process. Extensive research has demonstrated that cognitive gains made by young children require a high degree of parent involvement in order to be sustained over time. Whether a center-based, home based or combination center-home based delivery system was chosen, the impact of the program was related to the degree of active parent involvement. This requires first, that the basic life needs of the parents and family are met. Home visits, either alone or in combination with preschool classes for children, provided the best opportunity to meet the needs of both parents and child.

Parental change in the areas of both attitudes and behavior have been reported as a result of effective parent education programs. It would appear that the key to developing effective early childhood

programs -- in which gains made by children are maintained over time -- is to develop effective parent education programs.

Why Early Intervention for Handicapped Children?

Bettye Caldwell (1973) makes the comparison between the low-income, disadvantaged and the handicapped child vivid when she says:

Regardless of the external surroundings the environment of the young handicapped child is, by definition, depriving. If there is sensory deprivation, he cannot take the best of environments that are around him. If he has any kind of motor dysfunction, he cannot get up and move himself to find something better, or at least he cannot move himself to a situation where the environment might make a better match with his own current developmental state. It is a clear situation of the old rule of "haves" and "have nots." The "have nots" continue to get less. It is very important, as we plan for any kind of environmental design of enrichment, to be aware of this point and to take it almost as a given when we talk about early programs for the handicapped. It is almost impossible to think of a handicapped child who does not have a deprived early environment (p.7).

The Portage Project (Shearer & Shearer, 1972) lends some research findings to the limited body of literature which shows developmental gains by handicapped preschoolers enrolled in home visitor-parent training programs as compared to gains made by children in center-based programs. Randomly selected handicapped children from the Portage program were compared to randomly selected children from a nearby classroom program for culturally and economically disadvantaged children. Significantly greater

gains were found to be made by the Portage Project children in the areas of mental age, intelligence test scores, language development and socialization.

Passage of Public Law 94-142 has mandated that the state begin serving handicapped children at age three unless state law prohibits it. If the studies that have dealt with infant intervention, and the work of leaders in the field such as White (1975) and Bronfenbrenner (1975), were considered seriously it would seem that even age three is too late. For the child who has a handicapping condition or is at risk for developmental disabilities, early infant intervention becomes infinitely more crucial. Hayden and McGinnes (1977) have elucidated the reason for early intervention with the handicapped child as follows:

- 1) Early intervention does have an influence and that influence affects all areas of functioning.
- 2) Research has shown that there may be critical periods for the development of certain skills and that most of these periods may occur during the first three years of life.
- 3) Failure to provide a stimulating early environment leads not only to a continuation of the developmental status quo, but to actual atrophy of sensory abilities and to developmental regression.
- 4) All systems of an organism are interrelated in a dynamic way; failure to remediate one handicap may multiply its effects in other developmental areas, and may produce other handicaps (particularly social and emotional ones) that are secondary to the initial insult.

- 5) With a delay in remediating an intellectual or cognitive handicap, there is a cumulative achievement decrement even within a single area of functioning, apart from the danger of secondary emotional or social handicaps, that is, the condition is progressive -- the child's developmental status inevitably becomes worse with respect to other children as he grows older.
- 6) Early intervention has been shown to help: it can work to reduce the effects of a handicapping condition, and can do so more surely and rapidly than later intervention.
- 7) The cost-benefit ratio of early intervention usually makes it more economical than later intervention.
- 8) Parents need support during early weeks and months before patterns of parenting have become established.
- 9) Parents need models of good parenting behavior with a handicapped child and specific instructions for working with the child (pp. 153-54).

Some of these points may become clearer with further explanation. Early intervention has the advantage of exploiting critical periods for learning. A "critical period" refers to a relatively brief span of time when a child most easily learns certain skills. At no other time in a child's life will he be as sensitive to those factors in his environment which produce that particular skill. It is believed that if the child passes through the critical period without having achieved skill development, special intervention will be required in order to overcome the deficit.

Which skills have a critical period? At exactly what stage of a child's development does the critical period for a specific skill occur? Researchers do not yet know the answers to these

questions. It is believed, however, that most of these critical periods may occur during the first three years of the child's life (Hayden & McGinnes, 1977). For this reason, it is important that intervention with a handicapped child begin early. Because of the child's handicap, it is conceivable that he could pass through a critical period having never experienced the environmental stimuli which would permit skill development in that area. For example, a child must hear language before he can learn to speak. Even a deaf baby will cry, coo and babble the same as a hearing child until approximately six months of age. At that point his vocal experimentations begin to deviate from the norm due to the fact that he not only does not hear other's voices but also does not hear his own voice.

It would appear, however, that the early childhood years are a critical period for learning language patterns since children worldwide generally accomplish this somewhat remarkable feat before school entry. Regardless of the language spoken, most basic language structures are mastered and only refinements of the most complex structures are left to be learned by about age five. It would seem, then, that to provide the deaf child with a manual language system in the early months when hearing children are developing oral language would allow the child to capitalize on the critical period for language development.

Reisin (1973) found that visual deprivation during infancy produced extremely damaging effects upon the basic optic structure. Deprivation later in life had serious effects but was not nearly as damaging as when it occurred in infancy. It was also found that compensation for minor deprivations during critical periods could be made; however, more intense and prolonged experience was required that when the deprivation occurred later in life. Providing early intervention to handicapped children prior to the third year would appear to be imperative if the child is to benefit from the ultra sensitivity of the critical periods. To wait until age three is simply too late.

A delay in one area may produce additional handicaps. For example, a child who is unable to walk is deprived of many experiences which are readily available to a normal child. Walking over to a brightly colored object and exploring it with all five senses becomes an impossibility. Unless someone recognizes the child's needs to explore that object and bring it to her, the child must be satisfied with what she sees from a distance. She is deprived of knowing how it feels, what it looks like at six inches, how it sounds when pounded or shook, how it smells and, perhaps, even how it tastes. Her inability to walk has denied her experiences in four senses and limited her visual experience to a distance. In a sense, her immobility "handicapped" her additionally by depriving her of desirable experiences in all her senses. It is

possible that the same limitations for experience could occur several times a day unless the parents are taught ways to compensate for their child's special needs.

One widely cited example of how a handicap in one area affects functioning in other areas comes from a study conducted with parents of Down's syndrome children Bruium, Rynders and Turnure (1974) found that the language input used by the mothers of Down's syndrome children differed in quantity and quality from that used by mothers of "normal" children. It appears that, in addition to the disorder itself, the patterns of interaction used by the primary care-giver would handicap the child further by altering the normal language experiences that contribute to linguistic development. This would suggest that parents of handicapped infants need special help to assure that they respond to their child in natural and stimulating ways.

It has been demonstrated that disadvantaged low-income children benefit from early intervention. Still, some may ask, "What evidence is there that early education for a handicapped child will really help?" Most early intervention programs for young handicapped children are still in their infancy. For that reason, few follow-up studies have been conducted on children passing through those programs. The results available indicate that the programs do produce lasting benefits. For example, children who had been served by the Model Preschool Center for Handicapped Children at

the University of Washington were found to be placed in special education programs less frequently than control children who did not receive early intervention. What is more, gains achieved in pre-school were maintained. The program children scored as high as many "regular" children on intelligence tests. They were also found to be able to keep up with their regular classmates and were not retained (Hayden, Morris, Bailey, 1977).

SUMMARY

In summary, intervention for young handicapped children can produce gains when initiated early. In many ways the deprivation experienced by the young handicapped child is similar to the lack of environmental stimulation experienced by low-income, disadvantaged children. It's possible that serving handicapped children at age three as required by law may miss the most optimal time for learning basic developmental skills. By age three it is believed a child has passed through many of the critical periods of learning. If intervention is not begun early, the child's handicap in one area may have already begun to handicap him or her in other areas. Unless the needed support to parents of handicapped children is provided, their interaction patterns may unknowingly handicap the child even further. Good programs for handicapped children are effective.

As yet there are still many unanswered questions about how to maintain gains and how to determine effectiveness of different

approaches. It is, in part, to answer these questions that BEH has funded early childhood programs in the First Chance Network. Still, the direction seems clear. Intervention with young handicapped children and their parents needs to take place as early as possible.

Chapter 2

PARENTAL INVOLVEMENT IN EARLY EDUCATION

What Comprises Effective Parental Involvement?

In developing any preschool program, the designers must identify the needs of the population to be served. Secondly, the objectives must be selected. Almost simultaneously with determining objectives, a decision must be made on a service delivery system to attain those objectives. Lillie and Trohanis (1976) identify four service delivery systems from which preschool program planners can choose.

The first type of delivery system is a center-based program training system. It requires that children and/or parents be transported to a central location, usually a classroom in a public school or private setting. Ordinarily, center-based programs focus primarily on the child with parent involvement playing a secondary role.

The second type of service delivery model is the home-based model. Generally, home-based programs make the target of their educational intervention the parents, who in turn are responsible for implementing the program with their child. In such programs a staff member makes periodic visits to the parents and/or child within their own home.

The third type of service delivery system is the home-center-based system. These programs are a combination of home-based and center-based programs, since interaction between the staff and the families can take place either at the center site or within the home.

Programs using a combination system may transport children to the center for a daily program. Staff members may then visit the parents in the home to share information, develop parenting skills and observe child progress within the home setting. Other variations include programs that provide group meetings for the parents at a central location and extend staff services by providing follow-up in the home to assess the child's progress and encourage appropriate parent-child interaction.

The fourth service delivery system is the parent-implemented system which is consumer-operated. Parents manage and operate the program themselves. Theoretically, this system could utilize either a center site, home visitations or both.

Do Home-Based Programs Produce The Most Effective Parent Participation?

The importance of parental involvement in early childhood education is not new. Plato in The Republic urged assistance to mothers and families to help assure the child's optimum growth. This idea has continued throughout the development of the kindergarten movement in the United States. The federal government has assured some parental involvement by requiring parents to sit on advisory boards for programs funded through the Office of Human Development and Bureau for the Education of the Handicapped. The question then becomes, "To what degree should parents be involved, and what form should that involvement take?"

Goodson and Hess (1975) looked at the types of parent involvement used in early childhood programs. They classified the types

of family participation used by viewing parents as policy makers, as more effective teachers of their own children, as supportive resources for the school, or as parents in the role of becoming better parents. Lillie and Trohanis (1976) viewed parent participation objectives as providing social and emotional support to the family, exchanging information between the home and school, providing direct parent participation in the program, or enhancing the parent-child relationship. Karnes and Zehrbach (1972) urged program planners to maintain flexibility and to provide alternatives for involving parents in programs since individual needs among parents vary widely.

One of the primary questions for program planners then becomes, "to what degree should we involve parents and toward what kinds of parent involvement should we strive?" In part, this question must be answered individually for each parent based on individual strengths and weaknesses. However, research has provided guidelines and ideals toward which early childhood programs should strive. After an intensive investigation of 28 intervention programs designed to teach parents skills related to their young child, Goodson and Hess (1976) concluded that:

Assuming that the programs identified as having greater emphasis on parents did so in practice, then it appears that the more a program is focused on the parents, the more it is likely to produce significant and stable gains in children (p.47).

As a part of this study they analyzed two programs which

compared the effects of different parent involvement components. SKIP, Special Kindergarten Intervention Program, (Raclin, 1969) at Ann Arbor, Michigan, compared a supplementary classroom, a normal kindergarten experience, and a home visitor-parent involvement program. Designers concluded that child gains were related to parent involvement.

HOPE, Home Oriented Preschool Education, (Alfred and Hines, 1972) at Charleston, West Virginia, compared televised lessons, home visits and small group classes in a mobile classroom. They found that the home visit component was the most important factor in predicting children's cognitive and language development. However, this was the only component in which parents participated directly.

A small but growing body of longitudinal research from programs designed to serve low-income, disadvantages youngsters indicates that one-to-one parent teaching models, such as home visitor programs, produced immediate short term gains in intelligence that are resistant to "washout" over time (Goodson and Hess, 1976). Programs such as the Ypsilanti Perry Curriculum Demonstration Project (Weikart, 1970) have demonstrated in longitudinal studies that program children whose mothers received home instruction in a cognitively-oriented curriculum during the preschool years maintained significant differences in standardized intelligence test scores over the control group until the end of the third grade. At this point differences were still existent but they no longer reached a level that was statistically significant. The Early Training Project, which used a center-

based summer program with a home-based school year program, found significant differences in intelligence tests present as long as five years after intervention was terminated (Atyas and Gray, 1973).

Results of achievement test scores and measures of school success also appear to give home-based parent training programs an advantage. The Ypsilanti Perry Preschool Program found significant differences between program and control children through grade three on the California Achievement Tests (CAT) when differences no longer achieved significance (Weikart, n.d.). The Early Training Project found program children to significantly outscore control children through second grade. The program children maintained their superiority through the fourth grade, although score differences no longer reached significance (Atayas and Gray, 1973).

Other measures of school success indicate that a one-to-one parent training component is advantageous. The Ypsilanti Perry Preschool program found that at the end of the third grade, 72 per cent of the program children were at grade level compared to only 60 per cent of the control children. They also found fewer control children in remedial classes at the end of the third grade. The Learning to Learn Program (Sprigle, 1974) was a program that emphasized parent involvement through parent classes and periodic one-to-one parent teacher meetings in addition to the children's program. Follow-up results indicated 92 per cent of the program children received passing grades at the end of grade three compared to 60 per cent of the control

children. Twenty-six percent of the program children were found to be at or above grade level compared to eight percent of the controls. Only three percent of the program children were more than 1½ years below grade level on performance measures compared to 32% of the program children.

In 1974 Urie Bronfenbrenner conducted an in-depth survey of a variety of early intervention programs. He concluded that:

The evidence indicates that the family is the most effective and economical system for fostering and sustaining the development of the child. The evidence indicates further that the involvement of the child's family as an active participant is critical to the success of any intervention program. Without such family involvement, any effects of intervention, at least the cognitive sphere, appear to erode fairly rapidly once the program ends. In contrast, the involvement of the parents as partners in the enterprise provides an on-going system which can reinforce the effects of the program while it is in operation, and help to sustain them after the program ends (p.55).

In a 1977 study conducted by The Developmental Continuity Consortium for the Education Commission of the United States, 12 research groups collaborated to present the results of early education programs initiated for low-income children in the 1960s. They investigated three types of programs: home-programs, center-programs and combination home-center programs. Data collected by each research group at the initiation and conclusion of each program was examined. In addition, follow-up data were collected in 1976-77 when the subjects were nine to 18 years old. This included parent and youth interviews, intelligence and achievement

tests and school records. The study found that:

Early education significantly reduced the number of children assigned to special classes . . . and reduced the number of children held back one or more grades (p.13). All of the projects which found significant effects on special education were either home visiting programs or had some home visiting components. The two projects which found significant effects on grade failure had somewhat lesser degrees of parental involvement (p.108).

It is not known whether the improved school performance of program children is due to increased intellectual skills as a result of program participation or increased concern with the child's learning on the part of the parents.

In addition to measures of cognitive gains and increased school success, other less easily measured advantages have been shown for children enrolled in home-based programs. A review of the literature (Dudzinski and Peters, 1978) indicates that for parents enrolled in home-based programs, infant attachment begins earlier and is more intensive. Children have also been found to be more responsive to others and to demonstrate greater socio-emotional maturity.

Immediate improvements in the interaction pattern between the parent and child have also been demonstrated. Children have also been found to be more responsive to others. Programs with a high degree of parent involvement which analyzed parents' verbal and non-verbal behavior, found parents more often using language to reinforce the child's efforts as well as using language patterns which were more syntactically complex or varied. Three programs

which examined non-verbal behavior judged the program parents to be more responsive, warmer, more sensitive and more relaxed than control parents (Goodson and Hess, 1975).

In addition to advantages for program children, several advantages to home-based programs have been reported for other children in the family. A spill-over effect termed "vertical diffusion," which produced significant gains in younger siblings, was identified by Klaus and Gray (1968). It is thought that this effect may be due to changed parenting behaviors which have been generalized from the program child to other children in the family. Grossman (1972) speculates that a home-based program may be advantageous in reducing the stress which a handicapped child places upon a family. This may be due to the depth of the relationship possible between a home visitor and a family, which gives the parents and siblings the opportunity to express their frustrations surrounding the handicapped child.

Special advantages for parents have also been identified for home-based programs. In a review of the literature Dudzinski and Peters (1978) found a number of reports of mothers showing increased concern with their own development after involvement in a home visitor program. Mothers began to enroll in high school equivalency and other skill courses. They became interested in community and school affairs. They opened checking and savings accounts, and they began to express a desire to move out of low income housing projects. In short, "Mothers who participated in the 'home-based'

programs gained a sense of environmental mastery. They gain confidence in their own abilities and become hopeful instead of hopeless" (p.68).

To summarize the literature from programs for disadvantaged children, it would appear crucial for every early childhood program to focus considerable attention on the parents and to create a high degree of parent involvement. The parents must be motivated to accept the primary responsibility for the child's development, whether the option is for a center-based or a home-based program. It is only when parents accept this responsibility that gains remain stable over time.

The greatest degree of parent involvement is required by home-based programs. Although inter-program comparisons are different because of a lack of uniform assessment instruments and the difficulty of controlling all variables, Goodson and Hess (1975) concluded:

The home visit programs more consistently produced higher immediate gains and more often showed long term maintenance of gains . . . The home visits offer the possibility of a more intense teacher/parent relationship and a greater potential for personal rapport between the two (p.24).

Home-based programs need to be considered a viable, if not optimal, delivery system rather than an option to be considered only when a center-based program is not feasible. The Developmental Continuity Consortium recommends that all Head Starts be encouraged to adopt PCC (Parent-Child Centers) and Home Start Services . . .

as part of their regular programs, to obtain the benefits of earlier and mixed-locus intervention" (Lazar, et al., 1978, p.111).

Are Home Based Programs The Only Answer?

Home-based programs cannot, however, meet the needs of every family and cannot be considered the only option available to serve young children. Dudzinski and Peters (1978) warned:

Home-based programs, while showing impressive outcomes, will not always work. Disorganized families of parents who do not have the ability, time, energy or the will to participate will not benefit from a program that places the responsibility on the parents for promoting interaction with their children. Some parents have a legitimate need for a reprieve from their responsibilities from time to time. Just providing them with new skills will not be enough to permit them to be 'super parents' year after year. Yet, the home-based option is a viable alternative for many parents of multihandicapped and retarded children. (p.69).

A home-based program may not be the best alternative when both parents work full time. Karnes and Badger (1969) found that children whose mothers worked did not benefit from a home-based program. This may have been due to the fact that mothers who worked outside the home did not have enough time or energy to devote special programs for their children. The issue of two working parents will undoubtedly be a growing concern since the Department of Labor projects a 32 per cent increase between 1975 and 1985 in the number of working mothers ages 20 to 44 who have children under the age of five (Day Care Facts, n.d.).

In single-parent homes, which accounted for 11 per cent of American families in 1971 and are continually growing (Statistical Abstract

of the U.S. Bureau of the Census, 1972), the question is even more critical. It is unlikely that a parent who works full time and raises a family alone will be able to invest much time in daily lessons or activities for one child. For these families a combination home-center program may be preferable.

A home-based parent training program requires backup from a strong support system. The stress placed on a family when the basic needs for food, shelter and clothing are unmet would make the educational developmental needs of a child seem relatively unimportant. Dudzinski and Peters (1978) summarized this need by saying:

A final factor in successful programs is the degree to which they provide a complete family support system. The need for such a system varies with the population being served . . . A more comprehensive support system may be necessary for more severely disadvantaged or disorganized families. This might include nutritional guidance, instruction in home management skills, and referral to other social service agencies, as well as some monetary relief to ease the burden of survival (p.67).

A home-based program designed to serve handicapped youngsters may require some special family support services. Especially in the case of severely handicapped children, the need for respite care is crucial if the child is to be maintained in the home. The parents need at least the occasional opportunity to be alone, to take a vacation by themselves, and to be relieved of the intense care which their handicapped child may require. In addition, the parents may need counseling services in order to deal with their feelings regarding their handicapped child and the handicapping

condition. It is unrealistic to assume that these needs can be met by the extended family in a society as highly mobile as the United States today. It is, therefore, imperative in planning a home-based educational program for preschool handicapped children to examine closely what support services are available, the quality of those services, and the accessibility of them to the program families.

In looking at programs for the handicapped preschool child and the needs of the family, it is desirable that more than one placement alternative be available. Deno (1970) proposed what she called the Cascade System of Special Education Service. This model, designed for use in making placement decisions for school-age students, may be appropriate in looking at services for the preschool population as well. A number of alternative placements are implied in a "cascade of services." For example, the majority of mildly handicapped children could probably be served by parents in the home with the input of a trained home visitor. A moderately handicapped child with socioemotional needs might best be served in a center-based day care or Head Start program with services from specially trained personnel, such as a speech therapist, in addition to the parents' home program. A small minority of severely/profoundly handicapped children would still require total care such as might be provided in an institutional setting. In each case not only the needs of the child but the needs of the total family should be considered as well. Several alternatives should be available so that the most appropriate placement can be made.

Ideally, in order to best provide for each child, the entire continuum of services should be accessible. However, especially in rural areas, it may not be financially feasible to provide all alternatives within the continuum. Minimally, it would seem that a home visitor program, foster and respite care programs, and a residential program should be available placement options.

The necessity of providing a solid family support system does not negate the number of real advantages that exist when a home-based delivery system is selected.

1. Most importantly, gains made by children remain stable and are resistant to "washout," an effect that has been found to occur in programs that fail to involve the parents.
2. Programs can be totally individualized since interaction between the staff and families takes place on a one-to-one basis. This allows mildly and severely handicapped children, infants and preschoolers, to be served within the same program.
3. The entire family benefits since it has been shown that, in addition to child gains, siblings have also been shown to make gains, and parents have developed greater confidence to deal with their own problems.
4. A home-based program permits the delivery of services

to children in sparsely populated areas where transportation to a center would be extremely costly and scheduling would be difficult. Even when transportation could be provided, a center-based program might not be desirable due to differences in age and skill levels of the children to be served.

5. The necessity of providing well-equipped facilities designed for young children is eliminated. Even when space for a center program is available, it is often unsuitable for the young child who needs appropriately sized and located equipment. For the handicapped child, additional expense may be necessitated in making the facility barrier free.
6. Some programs have found that the cost-per-child makes a home-based program relatively inexpensive. Levenstein, Kochman, and Roth (1973) reported that a seven month program cost an average of \$400 per child.

Even with these major advantages; a home-based delivery system has its limitations.

A strong family support system must be in existence. A continuum of services needs to be available so that the most appropriate placement match can be made between the needs of the family and the needs of the child. Only when the basic criteria have been met can we expect a home-based program to be highly effective.

What Are The Characteristics of An Effective Home Visitor Program?

Simply providing a home-based program is not enough. Careful planning needs to be done and a specific program focus needs to be chosen. Haphazard programs may even have a negative effect on child development. Lambie, Bond and Weikart (1974) report that program children who had home visitors simply come in and play with them scored lower on subsequent testing than did the control children. For this reason we must approach home program planning carefully and make the focus of the intervention the parent rather than the child.

What qualities make a good home-based intervention program? Stevens (1976) analyzed several parent education programs for low income families and concluded that four components identified an effective program:

- 1) The parent consultants (home visitors) were provided with specific directions about how to conduct a home visit.
- 2) The training objectives were clearly specified.
- 3) Activities were developed to meet the objectives.
- 4) Activities were implemented consistently and uniformly.

He concluded that a home visitor, must "achieve a proper balance between prescriptiveness and personalization" (p.59).

Dudzinski and Peters (1978) who explored home-based programs as an alternative for handicapped children stress:

- 1) structuring the learning situation around a cognitively challenging task,

- 1) structuring the learning situation around a cognitively challenging task,
- 2) individualizing the goals, content and methods to the skill level of both the parent and the child.
- 3) focusing on the mother-child dyad rather than either one or the other,
- 4) stressing the parent's responsibility for the child's progress so that the home visitor plays a secondary role,
- 5) motivating parents to become involved with their child, and
- 6) assuring the existence of a complete family support system.

Goodson and Hess (1975) looked at over 20 early childhood programs for disadvantaged children and found those components that contributed to effective parent involvement programs included:

- 1) the degree of planning and structure in the curriculum or the validity of the curriculum in the parent's eyes, and,
- 2) how well the content functioned to involve the parents.

In addition they noted the findings of Barbrack and Horton (1970) who found the indifferent content produced different degrees of change in parents' teaching behaviors which might be important in determining long-term program effects.

By making some gross inter-program comparisons Goodson and Hess (1975) concluded some factors did not appear to be significantly related to child gains:

- 1) No one type of content -- language, sensory motor, cognitive or child development principles -- had a clear advantage in predicting magnitude of IQ gain for children in a program, either immediate or long term (p. 213).
- 2) None of the levels of structure (the degree to which the program defines parents' behaviors during the training and when working with the child) was clearly superior (p.215).
- 3) None of the three levels of specificity (of suggestions to parents) appeared to be systematically related to greater program effectiveness either on immediate or long term differences (p.216).

It should be remembered, however, that these authors were measuring program effectiveness on the basis of gains on intelligence test scores. Perhaps there are other more important, but less easily measured determiners of child and parent progress.

SUMMARY

In conclusion, the literature indicates that early childhood programs, both for disadvantaged and handicapped children, must focus their efforts on parent involvement in order for programs to be effective. Parent involvement appears to be most easily

and effectively obtained in home-based delivery systems where the parents retain full responsibility for the child's development.

Home-based programs have produced effective gains and advantages for children, siblings, and parents. The programs, however, must be carefully planned and executed to avoid doing more harm than good. The objectives and activities of the home visit must be developed around the needs and skills of both the parents and the child. The emphasis must constantly lie with the parents, giving them the skills and stressing the responsibility for their child's development. Beyond those basic minimal requirements, a great deal of leeway exists in order to best provide for the needs of each child and his or her family.

Characteristics of Good Parenting

Parent involvement has been shown to be the critical element in successful early childhood programs where gains are maintained beyond the conclusion of the program. What type of parent involvement is best for which parents under what condition? Research has not fully answered that question. Many more years of investigation will be needed before we will know which parents benefit most from what approaches. We do know, however, that home visitor programs have been able to achieve the highest degrees of parental involvement and that gains made by children in those programs have been maintained through the early elementary grades (Lazar, 1977).

Earl S. Schaefer (1972), a leader in the field of early childhood education, has described the unique relationship between a child and his or her parents. No other adult has a relationship with the child which exceeds the parents in priority, duration, continuity, amount, extensity, intensity, pervasiveness, consistency, responsibility and variability. He concludes, "The continuation of these different characteristics of parent-child interaction suggests that their cumulative impact upon the child's development would be substantial" (p.228). In this article he presents research to show that parental impact goes beyond the shaping of interests, attitudes, and opinions to affect intellectual and academic achievement as well.

The "cumulative impact" of the family upon the child's potential was underscored in a controversial book by Christopher Jencks, et al, (1972) entitled Inequality: A Reassessment of the Effect of Family Schooling in America. This research indicated that even quality schools could never overcome the socioeconomic effects of the class and culture in which a child is raised. The role of the family is paramount. It is for this reason that improving the young child's learning environment and the quality of parenting which he or she receives becomes a major responsibility of the educational system.

What behaviors characterize positive parenting? In a review of the literature regarding parental teaching styles, Honig (1975) found that the effective use of suggestions and instruction rather than controls and demands positively affected their child's

behavior. The amount of child-directed conversation in the home related significantly to child performance on developmental tests. The maternal language style -- rated by the complexity of words, the use of abstract rather than concrete speech, conversational context, and the amount and regularity of reading to the child -- affected the child's verbal ability. Children's test scores were also more highly related to family processes (which indicated the degree of parental interest and the intellectual expectations for the child) than to the family's socioeconomic level. Familial-cultural differences are thought to have a profound influence on the child's motivation for educational achievement and the emotional stability needed to approach cognitive tasks. We do know that some parenting behaviors produce better learning environments for young children than others. We do, however, need to continue our research to define these behaviors more carefully.

Clearly, parents are teachers. From the birth of their child until formal school entrance, they are the primary teachers. The influence of their teaching encompasses every aspect of the child's development from intellectual and language development to social and emotional growth. Their expectations and interest in the child have a profound influence upon the child's academic career. It may be that the effects of poor parenting may never be overcome no matter how good our schools may be. For this reason it is important that as a society we begin to view the family as the first and

foremost educational institution and to teach parents how to be better parents.

Stresses That Interfere With Good Parenting

Two types of stress interfere with parents' ability to provide positive parenting to their children. First, societal pressures often discourage positive parenting behaviors. Second, parents of handicapped children face additional stresses which interfere with their ability to meet the additional needs of an exceptional child.

Societal pressures are felt by the parents of every child. Lane (1975) has outlined some of the psychological and cultural stresses of our time and identifies several sources of problems for parents. She identified confusion among authorities as to what are the best childrearing practices as causing parents to be unsure of their role. Child abuse and neglect touch every segment of our society. Millions of families, especially in urban areas, live in hostile environments where parents are unable to protect their children from crime and pollution and to provide safe, clean playing environments. More and more children have inadequate supervision and care because both parents work and not enough licensed and inexpensive day care facilities exist. Parents sometimes become so confused by the complexity of decision making in a highly technological society that they simply give up on their problems and say, "What can I do about it?" Schools reflect the social and

economic unrest of society, and the problems reflected in public education leave parents without even this traditional backup system. Finally, in our mobile society help for parents from relatives, neighbors and friends has been removed and a professional void in this area still exists.

The General Mills American Family Report (1977) found five major trends and problems in family relationships and child rearing in our society. They are that:

1. Uncertainties about what is right and wrong have produced changes in values, American life styles no longer establish and reflect clear standards of appropriateness.
2. Increasing self-orientation takes the focus of the parents off the child. Society encourages individual pursuits and "doing your own thing" as opposed to furthering the family unit.
3. The family unit as an institution has been undermined by a constantly rising divorce rate.
4. Changes in the social environment, such as increased mobility, higher crime rate, and the continuing problems of low income families, place continual pressure on parents.
5. A laissez faire attitude on the part of parents has denied children the direction and discipline which they need.

The problems identified by these two studies are not confined to urban America. Among the rural poor we see many of the same problems that are found in inner cities. Problems such as divorce and uncertainty about appropriate child-rearing practices know no demographic or economic boundaries. Polluted air can

be found in Montana as well as Pennsylvania and California. Parents in Montana also are torn between seeking self-goals versus promoting family interests. Parenting in Montana is not much easier than parenting anywhere else. Because of the sparcity of agencies, especially in more isolated areas, it may even be more difficult than in most places.

The second source of parental stress is unique to the parents of handicapped children. A number of researchers have alluded to the stages through which parents must pass in order to adjust to their child's handicapping condition. (Boyd, 1951; Rosen, 1955; Grays, 1963; Wolfenberger, 1967) summarized these reactions as crises through which the family must pass. The first reaction to the diagnosis of the handicapping condition is the "novelty shock crisis." During this stage the parents' dreams for their child are dashed by the discrepancy that exists beteen the perfect child that was anticipated and the real child who can never fully realize those dreams.

The second crisis is the "value crisis," which may persist over many years. It refers to the anguish produced by the discrepancy between the parents' life values and the handicapped child's inability to perform in accordance with those values. For example, if the parents are academicians who value educational achievement, it may be extremely difficult to adjust to their retarded child who is capable only of performing simple, manual work. Another family

who places less value upon education may be much better able to adjust to their similarly handicapped child.

The third crisis is the "reality crisis." Sometimes external and uncontrollable situations make it very difficult for the child to remain in the home or community. A family who lacks a strong support system from their extended family or the community at large may be unable to care for their severely handicapped child at home. A divorce or death of a spouse may produce a reality crisis for the remaining parent.

Wolfensberger concludes:

If one is able to conceptualize the type of crisis a family experiences, one can more easily identify the treatments most likely to be effective. Parents in novelty shock need primarily information and support; those in the value crisis need prolonged counseling or personal therapy; those in reality crisis require practical, down-to-earth help such as training in home management, baby sitting, day care, sheltered workshops, and perhaps some form of residential placement (p.337).

Some professionals in the field have suggested that parents of handicapped children experience five stages in adjusting to their child's handicap that are similar to those experienced during the bereavement process described by Elizabeth Kübler-Ross (1969). The acknowledgement of the handicapping condition indicates the "death" of the ideal or perfect child which the parents have anticipated. Dr. Kübler-Ross describes these five steps in On Death and Dying as denial, anger, bargaining, depression and acceptance.

1. Denial. At first, and from time to time thereafter, a parent may deny that the diagnosis rendered is mistaken or somehow incorrect. Sometimes it is this denial that triggers the "shopping behavior" of trying to find a professional who can give a better diagnosis.
2. Anger. These feelings of anger, rage, envy or resentment may be directed at the person who delivered the diagnosis, a spouse, the siblings, self, other or God. Many times they center around the question, "Why me?" and "Why my child?"
3. Bargaining. Bargaining usually stems from guilt and results in some sort of promise. In terms of the parent of a handicapped child this might be indicated by a statement such as, "I will give up every club I belong to and work with him faithfully every day. Then will he be normal?"
4. Depression. The loss of the "ideal" child, the added financial burden, the increased physical burden, the guilt and fear of the future may cause the parents to experience severe or long lasting depression. Many times parents will need to talk during this stage and express what they simply are feeling. They need someone who is simply ready to listen.
5. Acceptance. Sometimes with a handicapped child this stage is referred to as "adjustment." Perhaps it is impossible to truly accept the handicapping condition, but daily the parents must find a way to adjust and to cope.

As members of the helping profession we must be aware that the parents of handicapped children often experience rejection of the child or situation, guilt, embarrassment, denial, bewilderment, grief, depression, self-pity, withdrawal from their friends and family, anger, blame, and feelings of futility.

A disabled child produces other stresses on a family in addition to the emotional stress related to the handicapping condition. A

handicapped child may require more care which produces greater physical strain as well. Their medical needs may place an economic burden on the family. In order to take advantage of better educational opportunities for the child, the family may be forced to move or be prevented from moving and taking advantage of career opportunities. The presence of a handicapped child in a family may cause problems with siblings who become jealous of the extra attention that the handicapped child receives or who are embarrassed by their handicapped sibling. Marital problems often erupt between the parents of handicapped children. A great percentage of these marriages end in divorce.

These problems are not limited to those children who are severely handicapped. Miller (1958) found that a child with a mild handicap may have more severe adjustment problems arising from a disturbed parent-child relationship than does a child with a severe handicap. This may be due to the fact that the parents' expectations of their child are unrealizable for reasons which are not easily observable nor readily apparent.

Professionals working with these families need to be aware of the profound influence of a handicapped child upon the entire family and must be prepared to help the parents cope with the problems that the child presents.

SUMMARY

The stresses of parenthood, even when the child is normal, are great. Society has undergone recent changes which make it increasingly difficult to know how to provide positive parenting to children. Roles for men, women and families have changed and people no longer have clear, well-defined guidelines by which to measure their success as individuals and parents. The problems of low-income families persist despite numerous programs to provide adequate housing, nutrition, employment and good learning environments.

The parents of handicapped children face even greater problems. In addition to the emotional grieving faced by these parents, there are often increased financial and physical burdens that take their toll on marriages and family relationships.

A home-based parent training program must take into account these needs so that an educational program can be effectively implemented. It is the responsibility of each home visitor to be able to recognize the needs of the total family and to respond to them appropriately. Listening skills and informal counseling techniques need, therefore, to be fostered and refined in paraprofessional home visitors who enter into the helping relationship with a family.

Successful Parent Teaching

The development of the handicapped child is less likely to occur as casually and informally as that of a "normal" child. For this reason educators need to teach parents how to structure experiences so that learning occurs as efficiently and rapidly as possible. In short parents need to be taught how to be teachers or educational agents for the child.

Many earlier childhood programs serving handicapped children are beginning to apply behavior science research to teaching techniques for parents (Shearer and Shearer 1973; Fredericks, Baldwin and Bradskey, 1973: Instructional Technology Project, n.d.). Most of these programs have found teaching parents skills such as identifying appropriate antecedents, behaviors, and consequences, generalization, task analysis, and shaping procedures to be helpful.

The Project Sunrise model then defines successful parent involvement by the degree to which parents demonstrate skills in the use of behavioral management techniques. Minimally, parents are required to present appropriate verbal and non-verbal antecedents (cues), to identify behaviors which do or do not meet criterion, to appropriately consequent those behaviors so that they are either reinforced or extinguished. Ideally parents may also be able to do a task analysis, develop their own shaping or generalization procedures, and create appropriate learning materials. Parental programs must, however, be individualized to meet parent

needs and abilities as well as those of their child.

Teaching Parents To Teach

The Project Sunrise model places paraprofessional home visitors in a teaching and helping relationship with the parents of young handicapped children. Paraprofessionals have been used in helping roles in comparable programs nationwide. Crisis centers, mental health programs and child care programs have used the services of volunteers and paid paraprofessionals to expand the services of their professional staff. A number of home visitor programs similar to that proposed in this model have found the paraprofessional home visitor to be an effective component in the service delivery system. Of the fourteen programs examined by the Consortium on Developmental Continuity (Lazar, 1977) eight had a home visitor component. Of those eight, seven of them used paraprofessionals in the role of home visitors. These home visitor programs were often the most effective in obtaining a high degree of parent involvement and, consequently, achieved the most long lasting gains. It would appear that paraprofessional home visitors played a major role in the success of these programs.

The Demonstration and Research Center for Early Education (DARCEE) at George Peabody College in Nashville, Tennessee employed paraprofessional home visitors in the First Generation Mother Study. The study indicated that "paraprofessional home visitors would be as effective as professionals and that paraprofessional and supervision was

potentially as effective as professional supervision" (Barbrack and Horton, 1970, p.137).

The Portage Project in Wisconsin employed paraprofessional home visitors to serve some of the handicapped children and their families who were recipients of the Portage services. In a comparison study Schortinghuis and Frohman (1974) found that the paraprofessionals were even more effective than the professionals in aiding children to acquire academic skills.

In addition to producing successful results, paraprofessional home visitors help to produce a cost-effective delivery system. Levenstein, Kochman and Roth (1973) found that the Mother Child Program cost an average of only \$400 per child for a seven-month program making it a relatively inexpensive program.

People serving as paraprofessional home visitors should be carefully screened and selected. Combs, et al. (1969) found that effective versus ineffective helpers could be distinguished not by the techniques used but by their personal beliefs and traits. Helpers perceived people as able to solve their own problems and manage their own lives. They also saw people as dependable, friendly and worthy. Helpers' self perceptions differed from non-helpers since they identified with people rather than things. They saw themselves as having the capacity to cope with problems and considered themselves self-revealing rather than self-concealing.

Selection of appropriate home visitors is only the first step. Because the home visitors are responsible for teaching parents specific skills, they must achieve competency in those skills themselves. In addition there are a number of other competencies which they need to carry out the specific duties related to serving young children with special needs and their families. Only with intensive training is it possible to assure that a home visitor possesses these competencies.

SUMMARY

Parent involvement in early education can take many forms depending upon whether the program is center-based, home-based or a combination center-home based delivery system. An advantage to a home based program is that generally parent involvement and responsibility for the child's development are greater than in other service delivery systems. Gains made by children in home-based programs appear to be longer lasting than gains made by children in center-based programs.

A strong support system must exist in order for a home-based program to be truly effective. This support system should assure that placement options are available, that the basic physical needs of the family are met and that the family has opportunities to meet their own social-emotional needs. Careful planning needs to take place in order to assure the success of a home-based program.

Good parenting and good teaching are nearly interchangeable.

Both, however, are difficult in today's society, and the job is even more difficult for the parents of handicapped children. In addition to the normal stress of parenthood, the handicapped child produces financial and emotional strains that affect not only the individual parents but sometimes the siblings and the marriage as well.

Behavioral sciences have provided answers regarding both parenting and teaching skills. By applying behavior management techniques in working with their young child, parents can structure tasks to assure that skills are learned. In the Project Sunrise model it is the paraprofessional home visitor who helps the parents learn the skills they need to use behavior management principles and to apply those skills daily in working with their own child.

Chapter 3

MODEL OVERVIEW

In August, 1977, Eastern Montana College at Billings, Montana became the recipient of a Bureau of Education for the Handicapped (BEH) grant funded through the Handicapped Children's Early Education Program (HCEEP). The purpose of HCEEP, or First Chance Programs as they are sometimes called, is to develop experimental projects which can serve as demonstration models to public schools or other agencies interested in serving young handicapped children and their families. Specifically, the purpose of Project Sunrise is to develop a model which can provide educational services to handicapped children, birth through six years, who live in rural areas of Montana. HCEEP funding for the development of this project is anticipated through June, 1980.

Two demonstration sites were established. One is located on the campus of Eastern Montana College. The other is located in the regional special education services building at Lewistown, which is about 130 miles from Billings. The purpose of the demonstration sites is to house the center staff and to provide the opportunity for families and paraprofessionals to come to a center for training. The center staff in Billings is composed of two early childhood special education specialists, a part-time center aide (graduate assistant), and a full-time secretary. The Lewistown center staff is comprised of one early childhood special education

specialist, a half-time secretary, and a part-time center aide.

During the development of the project, twelve central and south central Montana counties have been targeted for service delivery. They are Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Stillwater, Sweet Grass, Treasure, Wheatland and Yellowstone Counties. The Advisory Board is comprised of professional and parent representatives from these counties. In addition, the project director is located in the Institute for Habilitative Services at Eastern Montana College, which sponsors Project Sunrise.

The model itself is comprised of four basic elements -- the child, the parents, paraprofessional home visitors and the professional center staff. The following overview provides the basic structure of each component. In the following chapters each component will be dealt with in further detail.

THE CHILD

Project Sunrise serves children birth through six years of age with special needs and/or handicapping conditions. All handicaps are defined in accordance with Montana Rules and Regulations for Special Education 48-2.18(6)-S1860 to 48-2.18(6)-S18050. These definitions may be found in Appendix A. Eligibility for Project Sunrise is determined by:

1. The diagnosis of a handicapping condition by a doctor or a team of trained evaluation personnel (i.e. The Montana Center for Handicapped Children or local school

- district support personnel), or
2. screening results which indicate a need for further evaluation, including:
 - a) "questionable" or "abnormal" results on the Denver Developmental Screening Test (DDST), or
 - b) "rescreen" or "evaluate" results from the Comprehensive Identification Process (CIP), or
 3. a majority decision by the Project Sunrise Early Childhood Special Education Specialists. (For example, a child whose behavior problems presently place him at risk of being labeled emotionally disturbed at the time of school entry, would be considered by the staff for possible program inclusion).

The young child is viewed as a separate, unique individual who remains dependent upon the strength and integrity of the family during the early years. The handicapped child has the same basic needs as any normal child; however, learning experiences may need to be more highly structured to assure that skill acquisition will occur. Both normal and handicapped children demonstrate strengths and weaknesses in their skill development. The stronger family unit, the better the opportunity to capitalize on the child's individual strengths. The weaker the family unit, the more likely the strengths will be ignored and the deficits compounded. Therefore, the handicapping condition cannot be considered without looking at the whole

child within the context of the total family structure.

The Project Sunrise model views intervention as an amelioration of deficits in basic skill areas. Intervention teaches the parents to capitalize upon the child's skill strengths in order that the child may learn to cope more effectively. Priority skill deficits are task analyzed, or broken down into their component tasks, and structured so that by mastering each subskill the terminal skill can be learned. The curriculum content is organized in parallel units. For example, subskills A1, A2, and A3 allow mastery of skill A; and subskills B1, B2, and B3 allow mastery of skill B.

Curriculum Content

The five content areas which are considered a part of the young child's curriculum include motor, pre-academic skills, receptive and expressive language skills, social-emotional skills, and self-help skills. In addition to appropriate skill development in each of these areas, the staff may need to examine and aid the parents in correcting inappropriate behaviors which would interfere with the skill acquisition process. Such inappropriate behaviors might include tantrums, hitting, kicking, or self-stimulation. The succeeding portions of this section will serve to explain the necessity of including each content area within the child's curriculum.

Motor Skills

Motor skills refer to the large and small muscle activity of

the child. These skills begin with head control which is generally established at one or two months of age. By approximately thirteen months the child's balance and control is sufficient that the first steps can be taken. Prior to school entry the child's gross motor (large muscle) development ordinarily permits him to run, jump, hop, climb, crawl, swing, catch and throw a ball, ride a tricycle, walk a balance beam and turn summersaults as well as dozens of variations and combinations of these skills. From the helpless child, who at birth has nothing more than a few reflexive actions, develops an active, exuberant preschooler who can perform hundreds of actions and use his body in a thousand different ways.

Motor development ordinarily proceeds from the head downward (cephalocaudal development) and from the midline of the body outward (proximodistal development). Consequently, we would expect infantile batting and hitting activities to precede the pincher grasp needed for picking up a raisin or small piece of cracker. In addition, the gross motor skills need to be well developed before a child will be able to handle the fine motor (small muscle) movement that is required for school activities such as coloring, cutting, drawing and writing. It is primarily for this reason that motor skills are included in the curriculum.

Pre-Academic Skills

The second content area of the curriculum is composed of pre-academic skills. Basically, this includes those thinking and eye-hand coordination skills that precede skill development in reading,

writing and arithmetic. Visual perception and visual discrimination of shape, color and sex are included. Problem solving activities such as sorting, matching, sequencing and puzzle solving are considered prerequisites to several academic areas. Fine motor skills, especially in the fingers, are developed first through reaching-grasping-release activities, then through activities such as stacking, twisting, lacing and tying. Only when the child is able to accomplish many of these pre-academic skills will he be ready to execute the fine muscle movements of the fingers required in writing.

Cognitive skills are viewed from a Piagetian approach (Piaget, 1936, 1937, 1945). The age limits of the Project Sunrise Model include the sensorimotor and preoperational stages of development. This approach permits us to view the child's intellectual development by observing behaviors that the child exhibits. The staff is then able to structure activities in accordance with those behaviors so that the next cognitive task can be more easily mastered.

Receptive and Expressive Language Skills

The development of communication skills can be viewed as having two separate components. The first component is receptive language skills which permit the child to understand what is being said to him. We now know that a child only uses language structures for which he has developed a thorough understanding or "competence," as it is sometimes called.

The second component of language development is comprised of expressive language skills. Although a baby is capable of some vocal oral expression (namely crying) from birth, the first meaningful words are generally not uttered until about one year of age. After this two-and three-word combinations begin to be used to express entire adult sentences. By the time children are ready to go to school, they can normally use plural word forms, different verb tenses and all basic structures of their language community. The few exceptions and more complex syntactical structures may take several years to acquire.

Basically five systems are viewed as comprising the expressive language component. They are: 1) phonology, 2) syntax, 3) morphology, 4) semantics, and 5) pragmatics. Phonology refers to the sound system of a language. The sounds used in English differ from those used in German. They may both differ considerably from the various clicking and snapping sounds of some African languages. Some English sounds such as "l" or "r" may not be acquired by children until after school entry. A third-grader with a few articulation errors may still be within the normal range. Therefore, a preschooler with articulation errors does not generally create undo concern unless those errors are so severe as to interfere with normal attempts at communication. In that case, every effort would be made to first serve the child through a certified speech clinician.

Similarly, if the primary problem were stuttering (especially secondary stuttering) or a voice disorder such as vocal nodules, the first choice would be ordinarily be to serve the family through a speech clinician. If, however, the primary problem is delayed or deviant language development rather than a speech problem per se, the Project Sunrise staff is able to begin working with the child's parents teaching them how to structure language learning activities, how to change their own verbal behavior so they elicit more language from their child, and how to take advantage of normal language-learning situations. Even in these cases, where the problem lies in the realm of language rather than speech, every attempt will be made to involve a trained speech clinician in the diagnostic evaluation and Child Study Team.

The importance of including language skills as a major content area of nearly every handicapped child's curriculum cannot be over emphasized. Few handicapped children do not manifest at least some language/communication problems. Language proficiency is closely intertwined with the child's intellectual development, socioemotional growth, and even motor development. Progress has also been found to be greater in programs that emphasize language development than in those where language development was merely a by-product (Karnes, 1978).

We also know that academic success is closely related to a child's oral communication skills. Our school rooms require that

children be good listeners who are able to quickly and accurately follow directions. They require that children know how to ask and answer questions. We now know that language development is a prerequisite to reading (Vogel, 1974). If a child is unable to use a particular sentence construction, she is unlikely to understand its meaning when reading from the printed page. If a child cannot read, academic success is unlikely -- if not impossible.

It is the responsibility of Project Sunrise to aid parents in developing patterns of "communicative interaction" that encourage language development in the child. Rieke (1978) describes "communicative interaction" as:

... a continuing exchange -- a dialogue or alternating behaviors. When a child initiates the exchange, the role of the adult is to respond in such a way as to encourage the child to communicate again. For example, when the young child points to a pet and says, "My kitty", the adult might reply, "He's got pretty brown ears," The child will frequently add a further comment such as "and tail." When the child communicates again, the dialogue passes the interaction test: Communicator 1 to Communicator 2 and back to Communicator 1 again (p.16).

Clearly, communication is an integral part of every young handicapped child's educational program.

Social-Emotional Skills

Social skills, or the social-emotional area, refers to the development of the child as a feeling individual and an interacting member of society at large. The first skills developed in this area are smiling and responding to the attention of others. By the time a child is ready to go to school he should be able to

engage in fantasy play, play cooperatively with other children, and to respond in culturally appropriate ways to social situations.

It is important to understand how intermeshed emotional development and social development are. The child's emotional development refers to the self concept which the child holds of himself, his internal strength, and his reaction to new or different situations. It is difficult, however, to view emotional development except in the context of social situations. For example, when offered a horseback ride, one child's excitement and desire to go may be almost uncontrollable. A second may approach the horse several times as though she would like to go but is afraid to actually get on. A third may burst into tears and cling to his mother. How much of each child's behavior is due to internal, emotional factors and how much is due to social conditioning may never be known.

In part socioemotional skills and communication skills are nearly inseparable. Although a child without language skills may still be able to communicate through gestures, social interaction will be limited. As quickly as possible children should begin using words to express their requests and to obtain information. The very concept of communication -- a sender sending a message to a receiver who in turn provides feedback -- implies a social situation. This process is underscored in Reike's communicative interaction process discussed previously.

Self-Help Skills

Self-help skills refer to those skills in the areas of feeding, dressing, toileting and cleanliness that serve to make the child increasingly independent. Most of the skills in these areas should be mastered before a child reaches first grade, although help may still be needed for more difficult skills for a short time. Parents can be aided in structuring situations so their child can succeed independently. For example, a blind child may be taught how to dress himself by teaching him to locate the tag on the back of his T-shirt and the button sewed to the back of the elastic-waisted pants. Other self-help skills can be task analyzed and broken down into smaller, more easily acquired steps. The more self-sufficient that a young child is allowed to become, the better will be his self-image. In addition, not having to do everything for the handicapped child helps to relieve some of the stress on the family.

Inappropriate Behaviors

Some children exhibit behaviors which interfere with skill learning in other content areas of the child's curriculum. These behaviors can be broken into two general types -- inappropriate verbal behaviors and inappropriate physical behaviors. Those verbal behaviors considered inappropriate include excessive crying, screaming, whining, swearing, lying and talking back. Inappropriate physical behaviors include self abuse or abuse of others, throwing objects, tantruming, and self-stimulatory behavior.

Whenever possible, such behavior should be ignored and the child reinforced for appropriate responses. This may not, however, be possible nor desirable, especially if the child is hurting himself or others or if the behavior is damaging the relationship between the child and other family members. In these cases a behavior management program should be implemented to reduce the inappropriate behavior prior to (or in conjunction with) increasing skills in the other curriculum areas.

In a home-based program such as Project Sunrise, the parent assumes the responsibility for the curriculum of their own child. The curriculum for the young handicapped child is seen as serving to ameliorate deficits in basic skill areas while at the same time enhancing skill strengths in order to more easily cope with life situations. Each skill is task analyzed and the content is organized in parallel units. Skill mastery is then dependent upon mastery of a number of successive subskills. The curriculum is divided into five content areas -- motor skills, preacademic skills, receptive and expressive language skills and social-emotional skills, and self-help skills. In addition, it may be necessary to implement a behavior management program to reduce inappropriate verbal or physical behaviors.

The child's strengths and weaknesses must always be viewed within the context of the strengths and weaknesses of the entire family and

the home environment. A moderately handicapped child with concerned, interested parents who have a number of resources available to them may be better able to cope than a mildly handicapped child whose parents have almost no available resources and cannot implement a good educational program. Young handicapped children and their futures are clearly dependent upon the strengths of their families.

THE PARENTS

The success of the Project Sunrise model is dependent, to a large degree, on the ability of the parents to implement the program recommendations. By "parents" we are referring in most cases to the child's natural parents; however, in some cases the majority of the child's care may rest with another person, such as a foster parent, a grandparent or an older sibling. As the primary caregiver, this person would take the training needed to implement the child's educational program. Whenever possible, however, the responsibility for the child's development will ultimately be placed upon the parents who ordinarily maintain the highest degree of long-term involvement with the child. For example, it would appear imprudent to train the babysitter to do the activities with the child if the parents were unwilling to also implement the activities at home. If both parents are unwilling to participate and carry out the child's program, the child may be excluded from the program.

One basic consideration to be made before a parent teaching program is implemented is the degree to which the parents' basic

needs are being met. It is important to at least informally assess the socioemotional needs of the family in order to assure that the nutritional, housing, clothing, and employment needs have been met. In Project Sunrise staff is responsible for knowing how to tap available community support services -- not for directly providing that support. For example, it is the job of the staff to know where the nearest state employment service is located and for passing that information along to the family rather than to be directly responsible for aiding the parent in obtaining a job.

Other needs which a family may have could include the need for public health or mental health services, welfare payments, Supplemental Security Income benefits, food stamps, clothing through low cost charity organizations, help with child abuse, marital counseling, spiritual advise, help for alcohol or chemical dependency, respite care or foster care. Serious problems in any of these areas should be referred to the appropriate community agency. For this reason, it is important for the staff to know what resources are available and how they might be accessed by the family. In all cases the ultimate goal is to assure the family's independence rather than to foster a dependent relationship with the home visitor.

In addition to the support of the governmental and private agencies in a community, the family also needs a strong informal support system. This would include the extended family (grandparents, aunts and uncles and other relatives) and friends. It

is important to know to what extent the parents are able to rely upon this informal support system for respite care, emotional support, companionship and help in a crisis. In a mobile society, this may account for only very limited support. Even where the extended family lives geographically close there is no assurance that close-knit ties exist to uphold the family of a handicapped child.

Another important set of relationships to consider is those between the child, the parents, and the siblings. Certainly an impaired relationship between the target child and siblings could have a profound influence, especially on the child's socioemotional growth. In addition, an impaired relationship between a sibling and a parent could affect the learning climate of the home. It could be that a part of the Family Education Program might, in fact, be directed toward siblings rather than the target child specifically.

A home-based intervention program cannot isolate the child's situation from that of the total family. If the parents are to become the educational change agents for their child, their basic needs must have been met. For this reason a home visitor must know what agency resources are available to serve families in their area, and they must know how to go about accessing those services. In addition, they need to be aware of the informal support system provided by the extended family and the family friends. The relationships between the child and the siblings, and parents and siblings

should also be considered. Only by weighing the strengths of a family against its stresses will the staff know to what degree the basic needs are being met so that a home-based educational program may effectively be implemented.

THE HOME VISITOR

The home visitor component of Project Sunrise model is the liaison component between the early childhood special education specialists and the families. It is the home visitor who make the weekly contact with the families. In addition, they have weekly contact with the center staff to relay information about family needs and program progress.

Because of this liaison role, the most important skills which the home visitors must possess lie in the realm of interpersonal communication. It is their ability to observe and communicate those observations to the center staff that will form the vital-link between the handicapped child and the technical knowledge needed to plan and develop an effective educational program. It is also their responsibility to communicate the child's weekly program to the parents and to reinforce the parents' efforts at implementing that program. It is the home visitor who models the new activities and provides appropriate feedback to the parents when they teach the activity to the child.

The home visitors need a good understanding of the normal child development process. They must be able to recognize which

parental complaints about a child represent normal developmental patterns and which represent actual delays or deviance. In addition, as the community representative for Project Sunrise they need to be able to recognize developmental delays that potentially represent a handicapping condition so that a formal screening or evaluation would be warranted.

Skills in communication can be learned (at least in part) as can knowledge of child development. Some important attitudes which home visitors must bring to the position prior to training are an acceptance of all people -- regardless of differences in race, values, life-styles and religious beliefs. They must respect the rights and dignity of the families whom they serve. They must be sensitive to the needs of both adults and children. Additionally, they must be willing to serve as advocates for handicapped preschool children within their community.

To emphasize again the role of the home visitor, it is this liaison role that assures that services are actually delivered to families. The satisfaction of parents with the program will, in large part, be dependent upon the abilities and effectiveness of the home visitors. Even the best written IEP is of no value to the handicapped child unless it is implemented. Training the parents and motivating them to work with their child is largely the responsibility of the home visitor.

THE CENTER STAFF

The center staff is composed of three professional levels, each of which will be dealt with separately. They are:

- 1) the center aid
- 2) the early childhood special education specialist, and
- 3) the coordinator.

Basically, the center aides are responsible for the smooth operation of the center. It is their responsibility to assure that the necessary instructional materials are delivered to the home visitors and that data is collected from them for use in making educational decisions. If the center aides are non-professionals, their duties will be limited to these duties which are mostly clerical in nature.

Depending upon the background and professional training of the center aides, they may also serve as technical assistants to the paraprofessional home visitors. In this role they may also be involved in program planning for the child, including administering screenings, assessments and writing IIP's. Especially with new home visitors, they may need to aid in modifying and designing weekly lesson plans. In addition, they may be capable of much of the short term or weekly program planning needed to interpret a child's IIP into activities. Once basic educational decisions are made, they may be involved in interpreting them further for the home visitor and parents. The center aides may also be a part of the educational

team responsible for training the paraprofessional home visitors.

The early childhood special education specialists need the highest degree of professional training since they are responsible for all special education programming for the child and family. Their skills and knowledge must span normal childhood development, skill acquisition in young children, handicapping conditions, laws related to the field, an understanding of the programming process, skill in training and supervising paraprofessional home visitors and center aides.

Ultimately programming and implementation responsibilities lie with the early childhood special education specialists. Constant monitoring of progress allows the specialist to make those decisions which should assure more effective programming for the child.

The coordinator is ultimately responsible for the success of the entire model. He or she must make those decisions which will assure that the model is implemented appropriately at all levels from the center staff to the parents. Policies and procedures that permit program implementation are to be communicated to the staff through the coordinator. In addition the coordinator is responsible for supervising the early childhood special education specialists and coordinating the activities of the entire center staff.

Chapter 4

THE CHILD

Children are considered eligible for Project Sunrise Services if they meet one of the following criteria:

1. The diagnosis of a handicapping condition by a doctor or an interdisciplinary team of trained evaluation personnel (i.e. The Montana Center for Handicapped Children or local school district support personnel) or
2. screening results which indicate a need for further evaluation, including:
 - a) "questionable" or "abnormal" results on The Denver Developmental Screening Test (DDST), or
 - b) "rescreen" or evaluate results from The Comprehensive Identification Process (CIP), or
3. a majority decision by the Project Sunrise early childhood special education specialists. (For example, a child whose behavior problems presently place him at risk of being labeled emotionally disturbed at the time of school entry would be considered by the staff for possible program inclusion).

All diagnosed handicaps referred to in condition one, will be defined in accordance with the Montana Rules and Regulations for Special Education (48-2.18 (6) - S1860 to 48-2.18 (6) - S18050). These definitions may be found in Appendix A.

Eligibility under condition two above produces a temporary eligibility status. Following the diagnostic evaluation by the professional evaluation team, a permanent eligibility decision should be made. The parents are ultimately responsible for making this decision based on the test results and the recommendations of the interdisciplinary team.

Unless a diagnosis is made at birth it may be extremely difficult to know the etiology (cause) of a developmental delay. Even cerebral palsy in some of its most handicapping forms is difficult to recognize from normal developmental patterns before four months of age. The younger the child, the less reliable are intelligence test scores. In short, when looking at the very young child, there exist few ways of determining an appropriate diagnosis, even when developmental delays are known to be present.

For this reason it seems more judicious to begin non-categorical intervention based on an informal skill assessment, than to wait months or even years until an accurate diagnosis can be made to begin serving. By serving a child non-categorically, it is possible to avoid mislabeling and stigmatizing the child or impairing further the parent-child relationship. Also non-categorical intervention permits service to children with "high-incidence" handicaps, such as learning disabilities, which are nearly impossible to diagnose during early childhood.

One disadvantage is that there is a risk of over-identifying

children by including some whose delays are more environmental than genetic. However, even if this should occasionally be the case, intervention may eventually save the taxpayer money since the difference between the disadvantaged and handicapped child is often minimal and both have been found to benefit from early intervention. Program priority will, however, be given to those children whose development indicates the most severe delays and, consequently, who are the most severely handicapped.

It should be noted that temporary eligibility resulting from the screening scores may be overturned by the interdisciplinary diagnostic evaluation team. The CIP or DDST should be viewed merely as a determiner of those children who need further, in-depth evaluations, the diagnostic evaluation by the interdisciplinary team, in addition to observational data kept by the parents, should produce the actual eligibility decision. If the child's abilities fall within normal limits and parent-child interaction appears conducive to educational development, continued intervention may be unnecessary.

The Total Service Model

Identification

Before service can be delivered, potentially handicapped children must be identified and screened and eligibility must be determined. Child find or identification activities include distribution of the Project Sunrise brochure (Figure 4.1) and media coverage, as well as information passed by word-of-mouth within the



serving families with
preschool
handicapped children

Staple or tape closed for confidentiality

Name _____ Telephone _____

Address _____
Street or Box No., R.R. No. City County Zip

- | | |
|--|--|
| ☐ I would like more information on Project Sunrise | ☐ awkward use of legs and body; clumsy, uncoordinated |
| ☐ I (have/know of) a child 6 years or younger who worries me for the following reasons: | ☐ is not interested in being with others |
| ☐ poor speech, no speech, unclear speech | ☐ can't get along with family or friends |
| ☐ hearing problems | ☐ has severe tantrums |
| ☐ sight problems | ☐ has severe headaches or bangs his head |
| ☐ disabling disease or chronic illness | ☐ is over 3 and not toilet trained |
| ☐ birth defect | ☐ is/was slow to turn over, sit, or walk |
| ☐ physical handicap | ☐ doesn't respond; acts like he/she doesn't hear you. |
| ☐ seizures; head, arms or legs shake | ☐ seems sad, unhappy, or fearful much of the time |
| ☐ others; please describe _____ | |

Parents' name and address _____

Child's name _____ Age _____

She/he is _____ is not _____ receiving help.

Agency or agencies currently serving the family _____

Project Sunrise serves:

- children birth through 6 years with any handicapping condition.
- families residing in the following counties. Call Billings 657-2250 day or night.

Big Horn	Stillwater
Carbon	Sweet Grass
Golden Valley	Treasure
Musselshell	Yellowstone
- families residing in the following counties. Call Lewistown 538-7322 day or night.

Fergus	Petroleum
Judith Basin	Wheatland

Services offered by Project Sunrise:

- screening and evaluation of handicapped infants and young children.
- referral to a local agency whenever appropriate.
- assisting parents in the development of effective teaching techniques.
- building skills at the child's level of development through individual programs taught by the parents.

If you have concerns about a child, please call or complete the attached form. Cut along the dotted line, staple or tape shut and mail to Project Sunrise. A project representative will contact you.



Play is a part of the learning process for this three-year-old. Educational toys are available for handicapped children participating in this program.



This child CAN succeed!

But he needs help while he is still very young because of his handicap. Through Project Sunrise, his parents are learning how to teach him the skills he needs.

Project Sunrise
Institute for Habilitative Services
Eastern Montana College

Figure 4.1. *Cont.*

communities served. Providing the professional community -- doctors, nurses, public health employees, social workers, kindergarten, first grade and special education teachers, school principals and superintendents, ministers and day care workers -- with information about this service helps to generate appropriate referrals.

The identification process requires that the home visitors be advocates of young children within their communities. Because they have available some informal observational instruments, such as the Preschool Profile (Figure 4.2), and the Denver Prescreening Developmental Questionnaire (DPDQ) for each age level, the home visitor can informally serve as a community resource to help parents view their child's development in comparison to other children of approximately the same age. The purpose of identification is to locate those children who are delayed, whether the families desire services or not.

Referral

By observing their child's behavior relative to the behaviors indicated on the Preschool Profile or the DPDQ, the parent may then see the desirability of referring their own child for services by using the appropriate section of the brochure or by telephone. Even when the parents are unwilling to make a referral or are unaware of Project Sunrise services, a professional or even a neighbor can refer to the center staff those children in their community who appear to be delayed. A professional referral may be made by phone, brochure, or on an agency referral form (Figure 4.3).

Preschool Profile*

	GROSS MOTOR SKILLS	FINE MOTOR SKILLS	PRE-ACADEMIC SKILLS	SELF-HELP SKILLS
0-12 months	SITS WITHOUT SUPPORT. CRAWLS. PULLS SELF TO STANDING AND STANDS UNAIDED. WALKS WITH AID. ROLLS A BALL IN IMITATION OF ADULT.	REACHES. GRASPS. PUTS OBJECT IN MOUTH. PICKS THINGS UP WITH THUMB AND ONE FINGER (PINCH GRASP). TRANSFERS OBJECT FROM ONE HAND TO OTHER. DROPS AND PICKS UP TOY.	LOOKS DIRECTLY AT ADULT'S FACE. TRACKS OBJECTS (FOLLOWING THEM SMOOTHLY WITH EYES). IMITATES GESTURES. E.G. PUT A CUP, PEEK A DOG, BYE BYE. PUTS BLOCK IN, TAKES BLOCK OUT OF CONTAINER. FINDS BLOCK HIDDEN UNDER CUP.	FEEDS SELF CRACKER, MUNCHING, NOT SWALLOWING. HOLDS CUP WITH TWO HANDS, DRINKS WITH ASSISTANCE. HOLDS OUT ARMS AND LEGS WHILE BEING DRESSED.
12-24 months	WALKS ALONE. WALKS BACKWARD. PICKS UP OBJECT WITHOUT FALLING. PULLS TOY. SEATS SELF IN CHILD'S CHAIR. WALKS UP AND DOWN STAIRS WITH AID.	BUILDS TOWER OF 3 CUBES. PUTS 4 RINGS ON STICK. PLACES 1 PEG IN PEGBOARD. TURNS PAGES 2 OR 3 AT A TIME. SCRIBBLES.	FOLLOWS ONE DIRECTION INVOLVING FAMILIAR ACTIONS AND OBJECTS. E.G. GIVE ME (TOY). SHOW ME (BODY PART). GET A (FAMILIAR OBJECT). COMPLETES 3 PIECE FORWARD BOARD. WATCHES SIMILAR OBJECTS.	USES SPOON, SPILLING LITTLE. DRINKS FROM CUP, ONE HAND, UNASSISTED. CREWS FOOD. REMOVES GARMENT. ZIPS, UNZIPS LARGE ZIPPER. INDICATES TOILET NEEDS.
24-36 months	RUNS FORWARD WELL. JUMPS IN PLACE, TWO FEET TOGETHER. STANDS ON ONE FOOT, WITH AID. WALKS ON TIPTOE. KICKS BALL FORWARD. THROWS BALL, WITHOUT DIRECTION.	STINGS 4 LARGE BEADS. TURNS PAGES SINGLY. SNIPS WITH SCISSORS. HOLDS CRAYON WITH THUMB AND FINGERS. HOLDS FIST. USES ONE HAND CONSISTENTLY IN MOST ACTIVITIES. IMITATES CIRCULAR, VERTICAL, HORIZONTAL STROKES.	WATCHES SHAPES. STACKS 5 RINGS ON PEG, IN ORDER. DEMONSTRATES NUMBER CONCEPTS TO 2. (I.E., SELECTS SET OF 1 OR 2, CAN TELL HOW MANY 1 OR 2).	USES SPOON, NO SPILLING. GETS DRINK UNASSISTED. USES STRAW. OPENS DOOR BY TURNING HANDLE. PUSHES OR TAKES OFF COAT. WASHES, DRIES HANDS WITH ASSISTANCE.
36-48 months	RUNS AROUND OBSTACLES. WALKS ON A LINE. BALANCES ON ONE FOOT 5 SECONDS. HOPS ON ONE FOOT. PUSHES, PULLS, STEERS WHEELED TOYS. RIDES (I.E., STEERS AND PEDALS) TRIKE. USES SLIDE WITHOUT ASSISTANCE. JUMPS OVER 15cm (6") HIGH OBJECT, LANDING ON BOTH FEET TOGETHER. THROWS BALL WITH DIRECTION. CATCHES BALL BOUNCED TO HIM.	BUILDS TOWER OF 9 CUBES. DRIVES NAILS AND PEGS. COPIES CIRCLE. IMITATES CROSS.	WATCHES 6 COLORS. MAKES TOWER OF 5 BLOCKS, GRADUATED IN SIZE. DOES 3 PIECE PUZZLE. COUNTS TO 5, IN IMITATION OF ADULTS. DEMONSTRATES NUMBER CONCEPT TO 3.	POURS WELL FROM PITCHER. SPREADS SUBSTANCES WITH KNIFE. BUTTONS UNBUTTONS LARGE BUTTONS. WASHES HANDS UNASSISTED. CLEANS NOSE WHEN REMINDER. USES TOILET INDEPENDENTLY. FOLLOWS CLASSROOM ROUTINE WITH MINIMUM TEACHER ASSISTANCE. KNOWS OWN SEX. KNOWS OWN AGE. KNOWS OWN LAST NAME.
48-60 months	WALKS BACKWARD HEEL TOE. JUMPS FORWARD 10 TIMES, WITHOUT FALLING. WALKS UP DOWN STAIRS ALONE. ALTERNATING FEET. TURNS SOMERSAULT.	CUTS ON A LINE CONTINUOUSLY. COPIES CROSS. COPIES SQUARE. PRINTS A FEW CAPITAL LETTERS.	POINTS TO NAMES 6 BASIC COLORS. POINTS TO NAMES 3 SHAPES. WATCHES RELATED COMMON OBJECTS. E.G. SHOE, SOCK, FOOT. APPLE, ORANGE, BANANA. DEMONSTRATES NUMBER CONCEPT TO 4 OR 5.	CUTS FOOD WITH A KNIFE. E.G., SANDWICH, CELERY. LACES SHOES. KNOWS OWN CITY STREET. FOLLOWS INSTRUCTIONS GIVEN TO GROUP.
60-72 months	RUNS LIGHTLY ON TOES. WALKS A BALANCE BEAM. CAN COVER 2 METERS (6'6") HOPPING. SNIPS. JUMPS ROPE. SKATES.	CUTS OUT SIMPLE SHAPES. COPIES TRIANGLE. TRACES DIAMOND. COPIES FIRST NAME. PRINTS NUMERALS 1-5. COLORS WITHIN LINES. HAS ADULT GRASP OF PENCIL. HAS HANDEDNESS WELL ESTABLISHED (I.E. CHILD IS LEFT OR RIGHT HANDED).	SORTS OBJECTS ON ONE DIMENSION (I.E., BY SIZE OR BY COLOR OR BY SHAPE). DOES 15 PIECE PUZZLE. COPIES BLOCK DESIGN. NAMES SOME LETTERS. NAMES SOME NUMERALS. NAMES PENNY, NICKEL, DIME, QUARTER. COUNTS BY ONE TO 10. CAN TELL WHAT NUMBER COMES NEXT.	DRESSES SELF COMPLETELY. LEADS TO DISTINGUISH LEFT FROM RIGHT. TIES SHOE. BRUSHES TEETH UNASSISTED. CROSSES STREET SAFELY. RELATES CLOCK TIME TO DAILY SCHEDULE.

* This profile is a working draft only and was prepared by the Communication Program staff. Communication Disorders Specialists: Linda Lynch, Jane Burke, Sue Speltz, and Teachers: Donna Davidson and Mary O'Farrell. The authors would appreciate feedback on the usefulness of this profile which is in the process of revision.

The Communication Program is funded initially as part of the U.S. Office of Education, Office of Development Branch, Office of Educational Research and Statistics, at the College of Education and

Figure 4.2 Preschool Profile

MUSIC/ART/STORY SKILLS SOCIAL SKILLS AND PLAY SKILLS UNDERSTANDING LANGUAGE ORAL LANGUAGE

LISTENS TO MUSIC. LOOKS AT PICTURES IN BOOKS, PATTING, POINTING TO NAMING OBJECTS OR PEOPLE. PLAYS WITH WHOLE AND MOVEMENT, SHUFFS. MAKES STORIES.	SMILES SPONTANEOUSLY. RESPONDS DIFFERENTIALLY TO STRANGERS AND FAMILIAR PERSONS. PAYS ATTENTION TO OWN NAME. RESPONDS TO 'NO'. COPIES SIMPLE ACTIONS OF OTHERS.	LOOKS AT PEOPLE WHO TALK TO HIM. RESPONDS DIFFERENTIALLY TO VARIETY OF SOUNDS. E.G., PHONE, VACUUM, CLOSING DOORS, ETC. RESPONDS TO SIMPLE DIRECTIONS ACCOMPANIED BY GESTURES: E.G., COME, GIVE, GET.	MAKES DIFFERENT VOWEL SOUNDS. MAKES DIFFERENT CONSONANT VOWEL COMBINATIONS. VOCALIZES TO THE PERSON WHO HAS TALKED TO HIM. USES INFORMATION PATTERNS THAT SOUND LIKE PHRASES: E.G., INFORMATION THAT SOUND LIKE SCOLDING, ASKING, TELLING.
RECOGNIZES SELF IN MIRROR OR PICTURE. DEFERS TO SELF BY NAME. PLAYS BY SELF; INITIATES OWN PLAY ACTIVITIES. IMITATES ADULT BEHAVIORS IN PLAY. PLAYS WITH WATER AND SAND. LEADS, CARRIES, DUMPS. HELPS PUT THINGS AWAY.	RECOGNIZES SELF IN MIRROR OR PICTURE. DEFERS TO SELF BY NAME. PLAYS BY SELF; INITIATES OWN PLAY ACTIVITIES. IMITATES ADULT BEHAVIORS IN PLAY. PLAYS WITH WATER AND SAND. LEADS, CARRIES, DUMPS. HELPS PUT THINGS AWAY.	RESPONDS TO SPECIFIC WORDS BY SHOWING WHAT WAS NAMED: E.G., TOYS, FAMILY MEMBERS, CLOTHING, BODY PARTS. RESPONDS TO SIMPLE DIRECTIONS GIVEN WITHOUT GESTURES: E.G., GO, SIT, FIND, RUN, WALK.	ASKS FOR ITEMS BY NAME. ANSWERS 'WHAT'S THAT?' WITH NAME OF OBJECT. TELLS ABOUT OBJECTS OR EXPERIENCES WITH WORDS USED TOGETHER (2-3 WORDS): E.G., PHONE RINGS.
PARTICIPATES IN SIMPLE GROUP ACTIVITY: E.G., SING, CLAP, MARCH. COPIES PICTURE BOOKS, POINTS TO FIND DETAIL. PLAYS WITH WHOLE AND MOVEMENT, SHUFFS. MAKES STORIES.	PLAYS WITH OTHER CHILDREN. WATCHES OTHER CHILDREN, JOINS BRIEFLY IN THEIR PLAY. DEFENDS OWN POSSESSIONS. ENGAGES IN DOMESTIC PLAY. SYMBOLICALLY USES OBJECTS, SELF IN PLAY. BUILDS WITH BLOCKS IN SIMPLE LINES.	RESPONDS TO PUT IT IN AND PUT IT ON. RESPONDS BY SELECTING CORRECT ITEM: ONE VS. LITTLE OBJECTS. ONE VS. ONE MORE OBJECT. IDENTIFIED OBJECTS BY THEIR USE: E.G., SHOW ME WHAT MOTHER COOKS ON BY SHOWING STOVE, OR SHOW ME WHAT YOU WEAR ON YOUR FEET, BY SHOWING SHOE.	ASKS QUESTIONS. ANSWERS WHERE IS IT? WITH PREPOSITIONAL PHRASES: E.G., IN THE BOX, ON THE TABLE. ANSWERS WHAT DO YOU DO WITH A BALL? E.G., THROW, KICK. TELLS ABOUT SOMETHING WITH FUNCTIONAL SENTENCES WHICH CARRY MEANING: E.G., HE GO STOVE ON MY HUNGRY MOM.
RECOGNIZES PHASES OF SONGS. TELLS ABOUT SIMPLE STORIES (5 MINUTES). PLAYS WITH WHOLE AND MOVEMENT, SHUFFS. MAKES STORIES.	JOINS IN PLAY WITH OTHER CHILDREN; BEGINS TO INTERACT. SHARES TOYS, TAKES THINGS WITH ASSISTANCE. BEGINS DRAMATIC PLAY, ACTING OUT WHOLE SCENES; E.G., TRAVELING, PLAYING HOUSE, PREFERRING TO BE ANIMALS.	RESPONDS TO PUT IT BESIDE AND PUT IT UNDER. RESPONDS TO COMMANDS INVOLVING 2 OBJECTS: E.G., GIVE ME THE BALL AND THE SHOE. RESPONDS TO COMMANDS INVOLVING 2 ACTIONS: E.G., GIVE ME THE CAR AND PUT THE SHOE ON THE FLOOR. RESPONDS BY SELECTING CORRECT ITEM: E.G., HARD VS. SOFT OBJECTS. RESPONDS TO WALK FAST BY INCREASED PACE, AND TO WALK SLOWLY BY DECREASED PACE.	ANSWERS WHICH ONE DO YOU WANT? BY NAMING IT. ANSWERS IF...WHAT & WHAT...WHEN QUESTIONS: E.G., IF YOU HAD A PENNY, WHAT WOULD YOU DO? WHAT DO YOU DO WHEN YOU'RE HUNGRY? ANSWERS QUESTIONS ABOUT FUNCTION: E.G., WHAT ARE BOOKS FOR? ASKS FOR OR TELLS ABOUT WITH GRAMMATICALLY CORRECT SENTENCES: E.G., CAN I GO TO THE STORE? I WANT A BIG COOKIE.
RECOGNIZES PHASES OF SONGS. TELLS ABOUT SIMPLE STORIES (5 MINUTES). PLAYS WITH WHOLE AND MOVEMENT, SHUFFS. MAKES STORIES.	PLAYS AND INTERACTS WITH OTHER CHILDREN. DRAMATIC PLAY: CLOSED TO REALITY. ATTENTION TO DETAIL, TIME AND SPACE. PLAYS DRESS UP. BUILDS COMPLEX STRUCTURES WITH BLOCKS.	RESPONDS BY SHOWING PENNY-NICKEL-DIME. RESPONDS TO COMMAND INVOLVING 3 ACTIONS: E.G., GIVE ME THE CAR. PUT THE SHOE ON THE FLOOR. AND HOLD THE PENCIL IN YOUR HAND.	ASKS HOW QUESTIONS. ANSWERS VERBALLY TO BY AND HOW ARE YOU? TELLS ABOUT SOMETHING USING PAST TENSE AND FUTURE TENSE. TELLS ABOUT SOMETHING USING CONJUNCTIONS TO STRING WORDS AND PHRASES TOGETHER. E.G., I HAVE A CAT AND A DOG AND A FISH.
ABOVE ITEMS ARE SELECTED FROM THE SEQUENCED INVENTORY OF COMMUNICATION DEVELOPMENT, UNIVERSITY PRESS, UNIVERSITY OF WASHINGTON, 1975.			
RECOGNIZES OTHERS. PLAYS WITH WHOLE AND MOVEMENT, SHUFFS. MAKES STORIES.	CHOOSES OWN FRIEND(S). PLAYS SIMPLE TABLE GAMES. PLAYS COMPETITIVE GAMES. ENGAGES IN COOPERATIVE PLAY WITH OTHER CHILDREN INVOLVING GROUP DECISIONS, ROLE ASSIGNMENTS, FAIR PLAY. USES CONSTRUCTION TOYS TO MAKE THINGS. E.G., HOUSE OF LEGOS, CAR OF RIG A JIG.	SEE PRE-ACADEMIC SKILLS.	CHILD WILL HAVE ACQUIRED BASIC GRAMMATICAL STRUCTURES INCLUDING PLURALS, VERB TENSES, AND CONJUNCTIONS. FOLLOWING THIS DEVELOPMENTAL ABILITY, THE CHILD PRACTICES WITH INCREASINGLY COMPLEX DESCRIPTIONS AND COMPOSITIONS.

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 Project Director: Dr. Alice H. Hayden is Project Director.
 The Center for Handicapped Children, University of Washington, Seattle, Washington, 98195.

Figure 4.2 Continued

PROJECT SUNRISE

INSTITUTE FOR HABILITATIVE SERVICES

Project Sunrise, Institute for Habilitative Services, Eastern Montana College
Billings, MT. 59101 Telephone 657-2250

Project Sunrise, P. O. Box 128, Lewistown, MT. 59457, Telephone 538-7322

REFERRAL FORM

Part I: Identification

Child's Name John Doe County Yellowstone

Birthdate 10 / 7 / 74 Date of Referral 12 / 2 / 78
Mo. Day Yr. Mo. Day Yr.

Sex M Siblings and ages Pam (2) and Danny (6)

Referring person Carol Jones Position Public Health Telephone 452-2716
Nurse

Parent/Guardian James & Mary Doe Telephone 452-7306

Address Route #1, Benson, Mt. 59111
(Street or Route No./P.O. Box) City

Reason for Referral:

Down's Syndrome

Are there any unusual or special medical problems which the screener should know?

Results of evaluation of Montana Center for Handicapped Children indicate possible hearingloss at low frequencies.

(OPTIONAL) I am aware that this referral has been made to Project Sunrise.

Parent's Signature

Date

OUTCOME:

Parents contacted 12/13/78 by phone and screening set up for 12/10/78 at the family home.

Figure 4.3. Agency Referral form

Screening

Screening requires the administration of the Comprehensive Identification Process (CIP) and/or The Denver Developmental Screening Test (DDST), to any child on which diagnostic evaluation information is non-existent. A child may be considered temporarily eligible for services on the basis of a "rescreen" or "evaluate" result on the CIP or an "abnormal" or "questionable" result on the DDST. The Denver Eye Screening Test (DEST) and The Denver Articulation Screening Exam (DASE) may be administered as well. A child who obtains normal results on the screening test but is thought by a number of professionals to have problems will be considered for services by the early childhood special education specialists. A majority decision by the specialists makes the child eligible for program services.

Mass screenings for children ages two through five will generally require use of the CIP. Children are screened at five stations including hearing, vision, speech/language, medical and developmental. The medical and speech/language stations require at least one professional each; however, other stations may be manned by trained paraprofessionals.

Individual screenings or screenings of children younger than two years require the administration of the DDST. Generally this will be administered by the home visitor during the first home visit. The early childhood special education specialists and the parents should observe, and the general results should be shared with the parents following the screening. Following compilation of the DDST results with the informal observations of parent-child interaction patterns noted during

the visit, a decision will be made by the Project Sunrise staff regarding the child's temporary eligibility. The parents will then need to be notified of that eligibility decision, and they will, in turn, need to make a decision regarding their desire to participate. A child who has a diagnosis upon referral will not generally be administered a screening instrument.

If the parents indicate that services are desired at the time of screening, it may be advisable to share the Due Process Statement (Figure 4.4) with them at this time. Depending upon its perceived threat to the parents, the specialist and/or home visitor will ask them to sign the statement.

Assessment and Diagnostic Evaluation

When screening procedures indicate eligibility, the evaluation procedure begins. No assessment or evaluation is permitted until written consent is given on the Parental Consent to Evaluate Form (Figure 4.5). Some parents may be reluctant to permit the assessment and evaluation process so one or more home visits may be required to help them understand the reason for this process and to obtain their permission to begin. Nothing, however, can be done with the child except for screening until written permission is received.

The child's assessment and diagnostic evaluation might be outlined as follows:

PROJECT SUNRISE

Due Process Statement

It is very important that you be aware of and understand that you have the following rights:

1. To review all records related to the referral for evaluation.
2. To review the procedures and instruments to be used in the evaluation.
3. To refuse to permit the evaluation.
4. To be fully informed of the results of the evaluation.
5. To terminate program involvement at the parent(s) discretion.

Your cooperation is appreciated.

I, We _____ have read the above and understand our rights as stated.

Parent's Signature Date

Parent's Signature Date

Project Sunrise Representative Date

PROJECT SUNRISE

Parental Consent to Evaluate

My child, John Doe may participate in the
following psychological and/or educational assessments/evaluations.

Alpern-Boll Developmental Profile

CAMS - Motor, self-help and social/emotional assessments

UPAS - Preacademic and communication assessments

Home Observation for the Measurement of the Environment

Parent's Signature

Project Sunrise Representative

Date

Figure 4.5 Parental Consent to Evaluate Form

1. A functional skills assessment in the areas of deficit using the motor, self-help and social emotional portions of the Curriculum Assessment and Monitoring System (CAMS, Figure 4.6) and the pre-academic and communication portions of the Uniform Performance Assessment System (UPAS, Figure 4.7) are to be administered by the home visitor and completed within about a week of the screening and/or eligibility decision.
When a child exhibits behavior inappropriate to his or her age, the Specific Inappropriate Behavior Checklist from the UPAS (Figure 4.8) should be completed jointly by the parents and the home visitor.
2. A parent-child interaction assessment using the Home Observation for the Measurement of the Environment (HOME, Figure 4.9) is to be completed by the home visitor by the time the functional skills assessment is completed.
3. If one area of deficit is in expressive language, the home visitor facilitates and tape may record a 50-utterance language sample to be submitted to the center staff for analysis by a speech clinician. This recording then serves as a part of the data needed for the diagnostic evaluation.
4. A normative evaluation instrument, the Alpern-Boll Developmental Profile is then administered by the early childhood

CAMS SELF-HELP PROGRAM PLACEMENT TEST

Name: John Doe Birthdate: 10-7-74
Address: Route #1, Benson, Mt. 59111 Date of Test: 12-14-78
Phone: 452-7306 Examiner: Diane Smith

This placement test is given to determine at what step the child should start in the program. The test items are the criteria from the final step of each of the program objectives.

Give the placement test individually to each child in a quiet room. Gather all required materials before starting the test in order not to distract the child and prolong the test. The criterion for each step is printed at the end of each test item. If the child meets the criterion, circle YES. If he does not, circle NO. Whenever possible, the examiner should directly observe the child engaging in the behaviors described in the criteria. If this is not possible, the examiner should interview the mother and accept her report (RPT) regarding the child's behavior. When it is necessary to accept a report, RPT as well as YES or NO should be circled next to the test item.

The test is divided into four sections covering feeding, dressing, personal hygiene, and toileting. Within each section start testing the child at a level below the child's actual age. The child may be presented with a task three times before a NO is scored on that item. Discontinue testing in each section after the child has three consecutive incorrect responses. When the test is over for each section, print the numbers of the first three items to which the child responded incorrectly in the three boxes at the top of the test. These will be the first three objectives on which the child will work in each area.

In some of the test items the child's position is described and a position number is given in parenthesis. This number refers to the number of the photograph that illustrates the position described. Whenever a position number is noted the photograph should be consulted to ensure that the child is placed in the correct position for learning the skill properly. These position photographs appear on pages 68 to 72 of this text.

Feeding ☐11 ☐14 ☐18 Dressing ☐17 ☐22 ☐23 Personal Hygiene ☐12 ☐21 ☐30 Toileting ☐31 ☐38 ☐67B

Materials for CAMS Self-Help Program Test Kit

The following items are needed to administer the CAMS Self-Help Program Placement Test. They should be collected in advance and most of them can be stored in a box or bag. For more efficient use during testing, keep the items for each section separated.

The tester should refer to the placement test for a more detailed description of the items.

Feeding

1. bottle and nipple (premie nipple if needed)
2. small spoon
3. fork
4. knife
5. bowl
6. plate
7. small pliable plastic glass
8. straw with a 1/4 inch diameter hole
9. paper or cloth napkin
10. high chair (if available)
11. table
12. regular chair
13. a variety of foods (see the individual test items on the placement test)

Dressing

- child's clothing
1. loose fitting ankle socks
2. loose fitting coat
3. pants with elastic waist band
4. loose fitting hat
5. shirt or jacket with open-ended zipper in front
6. lace shoes
7. article of clothing with snaps
8. short-sleeve loose pullover shirt
9. shirt with buttons
10. pair of boots
11. clothes hanger

Personal Hygiene

1. two towels
2. washcloth
3. tub
4. baby shampoo
5. child's toothbrush
6. toothpaste
7. mirror
8. box paper tissues
9. soap
10. small glass
11. comb or brush
12. low stool (optional)
13. sink

Toileting

1. potty chair or toilet
2. toilet paper

Figure 4.6 Curriculum Assessment and Monitoring System

FEEDING SECTION

- ☒ YES ☐ NO RPT F1. THE CHILD CLOSES HIS LIPS ON A NIPPLE (0 months).
 Materials: bottle or breast nipple, premie nipple if needed
 Procedure: Cradle the child in your arm with his head slightly raised and bent forward (position 1). Insert the nipple into the child's mouth.
 Criterion: The child closes his lips on the nipple for three seconds.
- ☒ YES ☐ NO RPT F2. THE CHILD SUCKS A NIPPLE (0 months).
 Materials: breast, or bottle with regular nipple
 Procedure: Cradle the child in your arm with his head slightly raised and bent forward (position 1). Insert the nipple into his mouth.
 Criterion: The child sucks three times on the nipple.
- ☒ YES ☐ NO RPT F3. THE CHILD OPENS HIS MOUTH ON THE APPROACH OF A NIPPLE (0 months).
 Materials: breast, or bottle with regular nipple
 Procedure: Cradle the child in your arm with his head slightly raised and bent forward (position 1). Bring the nipple close to, but not touching his mouth.
 Criterion: The child opens his mouth before his lips are touched by the nipple.
- ☒ YES ☐ NO RPT F6. THE CHILD BRINGS HIS HAND TO HIS MOUTH (5 months).
 Materials: none
 Procedure: Place the child on his stomach or side on a flat surface. Place his hands in his line of vision so that he notices them.
 Criterion: The child brings one of his hands to his mouth for at least one second.
- ☒ YES ☐ NO RPT F7. THE CHILD CLOSES HIS LIPS ON A SPOONFUL OF STRAINED FOOD (7 months).
 Materials: small spoon, bowl of strained food, high chair (optional)
 Procedure: Seat the child upright on your lap or in a high chair. Place a small amount of food on the spoon and tip it onto the front half of his tongue (position 3).
 Criterion: The child closes his lips to remove strained food from a spoon.
- ☒ YES ☐ NO RPT F8. THE CHILD MOVES FOOD AROUND HIS MOUTH WITH HIS TONGUE (7 months).
 Materials: soft food (such as, soft cheese or pudding), spoon, mirror, high chair (optional).
 Procedure: Seat the child upright on your lap or in a high chair. Place food in the child's mouth with a spoon. Place the first spoonful on one side of his mouth and the next one on the other side (position 4).
 Criterion: The child moves the food around with his tongue to swallow it.
- ☒ YES ☐ NO RPT F9. THE CHILD REACHES FOR AND HOLDS THE BOTTLE OR BREAST (9 months).
 Materials: bottle or breast
 Procedure: Cradle the child in your arm with his head slightly raised and bent forward (position 1). Hold the bottle or breast within his reach. As he reaches for and grasps it, place the nipple in his mouth.
 Criterion: The child reaches for and holds the bottle or breast for 20 seconds.
- ☒ YES ☐ NO RPT F10. THE CHILD DRINKS FROM A GLASS HELD FOR HIM (9 months).
 Materials: small, pliable plastic glass, beverage, high chair (optional)
 Procedure: Seat the child upright on your lap or in a high chair as you stand behind him. Place the rim of the glass on his bottom lip and tip the glass so that he sips a small amount of beverage (position 5). Lower the glass, but rest it on his bottom lip between each sip.
 Criterion: The child drinks three sips from a glass held for him.
- YES ☒ NO RPT F11. THE CHILD EATS LUMPY OR "JUNIOR" FOOD (10 months).
 Materials: cooked or soft chopped foods (such as, vegetables, macaroni, rice, soft fruits), dish, spoon, high chair (optional)
 Procedure: Seat the child upright on your lap or in a high chair. Put a small amount of food onto the end of the spoon and tip it onto the front half of his tongue.
 Criterion: The child swallows three bites of lumpy food.

Figure 4.6 Continued

Sample Page

SOCIAL-EMOTIONAL PLACEMENT TEST

15	16	18
----	----	----

Name: John Doe Birthdate: 10-7-74
Address: Route #1, Benson, Mt. 59111 Test Date: 12-14-78
Phone: 452-7306 Examiner: Diane Smith

This placement test is given to determine at what step the child should start in the program. The test for the Social-Emotional Program is somewhat different from the other CAMS placement tests. Each objective is divided into several questions. In order for a child to pass each objective, he must pass each of the individual questions. For example, the first objective is "Responds to a Person." Under this objective five questions are given. The child must demonstrate that he is able to pass all of these questions in order to receive credit for that objective. Because of the nature of social-emotional development, it is often necessary to rely on the mother's confirming that the child is capable of passing a question. In this placement test, *RPT* (Reported by Mother) will be viewed as *YES*.

Figure 4.6 Continued

Give the placement test individually to each child in a quiet room with the mother present. When possible, the examiner should attempt to evoke the desired behavior by directly interacting with the child or by observing the interaction between the mother and child. When this is not possible, the examiner should interview the mother.

Start testing the child at a level below the child's actual age. Discontinue the test after the child has seven consecutive incorrect responses. When the test is over, print the numbers of the first three items to which the child responded incorrectly in the three boxes at the top of this page. These will be the first three objectives on which the child will work.

- | | | | |
|--------------------------------------|----|-----|---|
| ☒ YES | NO | RPT | 1. THE CHILD RESPONDS TO A PERSON
___ Is the child quiet when picked up?
___ Is the child's body relaxed when held?
___ Does the child follow a moving person with his eyes?
___ When upset, will the child be comforted when held? |
| ☒ YES | NO | RPT | 2. THE CHILD IS ABLE TO RESPOND NEGATIVELY (CRYING)
___ Does the child cry or fuss when he wants to gain attention?
___ Does crying cease when the child has been fed, changed, comforted or placed in a new environment? |
| ☒ YES | NO | RPT | 3. THE CHILD IS ABLE TO RESPOND POSITIVELY (SMILING AND COOING)
___ Does the child smile when spoken to, held, or played with by mother?
___ Does the child gurgle or coo when spoken to, held, or played with by mother? |

Figure 4.6 Continued

93

RHYMES AND SONGS

CURRICULUM

ACTIVITIES

49F 555 566

CAMS MOTOR PROGRAM PLACEMENT TEST

Name: John Doe Birthdate: 10-7-74
 Address: Route #1, Benson, Mt. 59111 Test Date: 12/15/78
 Phone: 452-7306 Examiner: Diane Smith

This placement test is given to determine at what step the child should start in the program. The test items are the criteria from the final step of each of the program objectives.

Give the placement test individually to each child in a quiet room. Gather all required materials before starting the test in order not to distract the child and prolong the test. Be sure to score each of the child's responses as it is given. The criterion for each step is printed at the end of each test item. If the child meets the criterion, circle YES. If he does not, circle NO.

Start testing the child at a level below the child's actual age. The child may be presented with a task three times before a NO is scored on the item. Discontinue the test after the child has seven consecutive incorrect responses. The letters G and F which follow the item numbers indicate which items are gross motor skills and which are fine motor skills. When the test is over, print the numbers of the first three items to which the child responded incorrectly in the three boxes at the top of this page. These will be the first three objectives on which the child will work.

Materials for CAMS Motor Program Test Kit

The following items are needed in order to administer the CAMS Motor Program Placement Test. They should be collected in advance, and most of them can be stored in a small box or bag.

1. a lightweight inflatable ball, ten to twelve inches in diameter
2. a small ball, two to three inches in diameter
3. eight to ten one-inch blocks
4. three one-inch beads with a hole through the center
5. a shoe string with a tip which is one to one-and-one-fourth inches in length
6. an unbreakable cup
7. a child's book
8. a rattle
9. a roll of one-inch wide masking tape
10. a small unbreakable pitcher
11. a small pill bottle with a mouth which is three-quarters inch to one-inch in diameter
12. a tape measure (which is used to measure the heights of various objects in the testing area for the items where the child is required to jump from a specific height)
13. a tricycle
14. a ten-foot balance beam. (This can be a simple ten-foot piece of four-by-four-inch wood placed on the floor)

☒ YES

NO

1G. THE CHILD RAISES HIS HEAD OFF THE FLOOR FOR ONE SECOND WHILE ON HIS STOMACH (1 month).

Materials: a favorite toy

Procedure: Put the child on the floor on his stomach with his arms bent and his hands near his head (position 2). Sit in front of him and get his attention with a toy.

Criterion: The child raises his head for at least one second to look at the toy.

Sample 4.6 Continued

Name _____
I.D. Number _____ Birthdate ____/____/____

Items in CAPS and a line require number correct entered.

Birthdate 10-7-78

Sample Page KEY: _____ CATEGORY KEY: _____
N = not applicable M = motor
I = instruction S = sensory
A = adaptation C = cognitive
P = prosthetic I = interactive
X = no chance Circle around category key
E = no equipment indicates a basic skill.

Testing Date ____/____/____ Quarter ____						Testing Date ____/____/____ Quarter ____						Testing Date ____/____/____ Quarter ____								
Receptive						Expressive						Receptive								
IEP	+/-	note	+/-	note	+/-	note	IEP	+/-	note	+/-	note	+/-	note	IEP	+/-	note	+/-	note	+/-	note
1. ⑤ respond to sound	○						29. M emit vowel sounds spontaneously	○						53. use prepositional phrases-	○					
2. ① look toward verbalization	○						30. ① different pleas, nonpleasurable sounds	○						① a. 2 different	○					
3. turn to sound-							31. M emit consonant sounds spontaneously	○						① b. variety	○					
⑤ a. to right	○						32. I emit vowel-consonant combos.	○						54. use adjectives-	○					
⑤ b. to left	○						33. I imitate talk w/ sounds	○						① a. 3 different	○					
4. ① respond to name	○						34. I babbling sounds like sents.	○						① b. variety	○					
5. ① respond to word/gesture	○						35. ① uses gestural language	○						55. ① use "to be"	○					
6. ① respond to "come here"	○						36. ① imitate 2 motor actions	○						56. ① use negatives	○					
7. ① respond to "look here"	○						37. I imitate nonspeech sounds	○						57. use possessive pronouns-	○					
8. ① respond to names of toys, clothes	○						38. imitate 4 speech sounds-	○						① a. 2 different	○					
9. ① respond to doll, ball	○						I a. vowels	○						① b. variety	○					
10. ① respond to single action commands	○						I b. consonants/vowels	○						58. I describe function of object	○					
11. ⑤ discriminate non-speech sounds	○						39. ① return "bye-bye"	○						59. use past tense-	○					
12. ① respond to names of animals, food, items in room	○						40. ① ask for names of objects	○						① a. 2 different verbs	○					
13. ① respond to in	○						41. ① name wanted object	○						① b. variety	○					
14. ① respond to on	○						42. ① respond negatively	○						60. ① imitate sentence	○					
15. ① respond to out	○						43. ① respond affirmatively	○						61. use complete sentences-	○					
16. ① respond to off	○						44. use verbs-	○						① a. complete	○					
17. ① respond to big, little	○						① a. 2 different	○						① b. complete and correct	○					
18. ① respond to body parts	○						① b. variety	○						62. I answers if...what, when questions	○					
19. ① respond to under	○						45. ① use 2-word phrases	○						63. I complete opposites	○					
20. ① respond to beside	○						46. ① speaks understandably	○						64. I identify materials	○					
21. ① respond to 2-object command	○						47. use pronouns-	○						65. I 3 idea story	○					
22. ① respond to 2-action command	○						① a. 2 different	○						66. I relate familiar story	○					
23. ① select rough, smooth/hard, soft	○						① b. variety	○						67. use future tense-	○					
24. ① respond to 3-action command	○						48. ① use regular plurals	○						① a. 2 different	○					
25. ① select real, unreal object	○						49. ① tell action in pictures	○						① b. variety	○					
26. ① select picture showing action in past, present, future	○						50. ① relate immediate experiences	○						58. I use dependent clauses	○					
27. ① select picture satisfying 2 conditions	○						51. ask questions-	○						69. I tell similarities/differences	○					
28. ① # LITERAL DETAILS RECALLED (of 3)	○						① a. 2 different forms	○						# additional IEP objectives	○					
# additional IEP objectives	○						① b. variety of forms	○						SET	MASTERCED	MASTERCED	MASTERCED	MASTERCED	MASTERCED	
52. ① use 4 word phrases	○																			

Figure 4.7 Uniform Performance Assessment System

Name _____
 I.D. Number _____ Birthdate ____/____/____

Items in CAPS and a line require number correct entered.

Testing Date ____/____/____
 Quarter ____

Pre-Academic, 0-6 Year Scale - RECORD SHEET

Uniform Performance Assessment System
 1978 University of Washington

Testing Date ____/____/____
 Quarter ____

NOTE KEY:

N = not applicable P = prosthetic
 I = instruction X = no chance
 A = adaptation E = no equipment

CATEGORY KEY:

M = motor I = interactive
 S = sensory Circle around category key
 C = cognitive indicates a basic skill.

Visual Perception	IEP	+/-	note	+/-	note	+/-	note	+/-	note
1. ☐ focus eyes	☐								
2. ☐ look at face	☐								
3. ☐ eyes track-	☐								
a. 90°	☐								
b. 180°	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED
Reach, Grasp, Release									
4. ☐ reach	☐								
5. ☐ grasp handle	☐								
6. ☐ cube in each hand	☐								
7. ☐ voluntary grasp-	☐								
a. rake	☐								
b. finger-thumb	☐								
c. pincer	☐								
8. ☐ transfer cube	☐								
a. supported	☐								
b. unsupported	☐								
9. ☐ CUBES STACKED (of 10)	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED
Perceptual-Motor									
11. ☐ rings on stick	☐								
12. ☐ pegs in hole	☐								
13. ☐ turn pages	☐								
14. ☐ string beads	☐								
15. ☐ hammer pegs	☐								
16. ☐ snip paper	☐								
17. ☐ cut 2" strip	☐								
18. ☐ cut-	☐								
a. line	☐								
b. circle	☐								
19. ☐ 3-block bridge	☐								
20. ☐ match parquetry-	☐								
a. P114-3	☐								
b. P114-10	☐								
21. ☐ copy parquetry	☐								
22. ☐ completes picture	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED

Sequencing	IEP	+/-	note	+/-	note	+/-	note	+/-	note
23. ☐ imitate motor sequence	☐								
24. ☐ put cylinders in size order	☐								
25. ☐ repeat block/bead pattern	☐								
26. ☐ orders 3-part temporal sequence	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED
Puzzles									
27. ☐ shape in template	☐								
28. ☐ 3-piece puzzle	☐								
29. ☐ 7-piece puzzle	☐								
30. ☐ 15-piece puzzle	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED
Writing									
31. ☐ scribbles	☐								
32. ☐ imitate loop stroke	☐								
33. ☐ imitate zig-zag stroke	☐								
34. ☐ hand preference	☐								
35. ☐ imitate circle	☐								
36. ☐ imitate plus	☐								
37. ☐ trace line	☐								
38. ☐ imitate square	☐								
39. ☐ mature pencil grasp	☐								
40. ☐ PARTS OF PERSON DRAWN	☐								
41. ☐ copy first name	☐								
42. ☐ print first name	☐								
43. ☐ CAPITAL LETTERS PRINTED (of 26)	☐								
44. ☐ LOWER CASE LETTERS PRINTED (of 26)	☐								
45. ☐ NUMERALS WRITTEN (0-9)	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED

Discrimination	IEP	+/-	note	+/-	note	+/-	note	+/-	note
46. ☐ match objects	☐								
47. ☐ match lotto	☐								
48. ☐ sort pegs/blocks	☐								
49. ☐ sort on 2 dimensions	☐								
50. ☐ match colors	☐								
51. ☐ COLORS SELECTED (of 6)	☐								
52. ☐ COLORS NAMED (of 6)	☐								
53. ☐ match shapes	☐								
54. ☐ SHAPES SELECTED (of 3)	☐								
55. ☐ SHAPES NAMED (of 5)	☐								
56. ☐ chooses design that is different	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED
Pre-Reading									
57. ☐ match letters	☐								
58. ☐ identify rhyming words	☐								
59. ☐ LETTERS SELECTED (of 26)	☐								
60. ☐ LETTERS NAMED (of 26)	☐								
61. ☐ discrim. consonant sounds	☐								
62. ☐ discrim. vowel sounds	☐								
63. ☐ COMMON SIGHT WORDS READ (of 10)	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED
Pre-Math									
64. ☐ NOTE COUNTED (to 50)	☐								
65. ☐ 1:1 correspondence	☐								
66. ☐ OBJECTS COUNTED (of 10)	☐								
67. ☐ NUMERALS SELECTED (of 11)	☐								
68. ☐ NUMERALS READ (of 20)	☐								
69. ☐ NUMERALS ORDERED (of 10)	☐								
70. ☐ SETS MATCHED (no. to quantity of 11)	☐								
71. ☐ identifies more/less	☐								
72. ☐ QUANTITIES MATCHED (of 8)	☐								
73. ☐ names number following stated number	☐								
74. ☐ identifies half	☐								
75. ☐ adds sets to 5	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED
Right, Left									
76. ☐ shows right, left	☐								
# additional IEP objectives	SET	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED	MASTERED

Name _____

I.D. Number _____ Birthdate ____/____/____

Items in CAPS and a line require number correct entered.

NOTE KEY:

N = not applicable
I = instruction
A = adaptation
P = prosthetic
X = no chance
E = no equipment

SCORE KEY:

0 = no problem
1 = minor problem
2 = major problem

Testing date ____/____/____
Quarter _____

Testing date ____/____/____
Quarter _____

INAPPROPRIATE VERBAL BEHAVIOR					INAPPROPRIATE PHYSICAL BEHAVIOR				
IEP	0/1/2 note	0/1/2 note	Q/1/2 note	0/1/2 note	IEP	0/1/2 note	0/1/2 note	0/1/2 note	0/1/2 note
1. talks out	#					15. fails to follow teacher directions	#		
2. talks back	#					16. abuses others	#		
3. laughs inappropriately	#					17. self-abusive behaviors	#		
4. cries	#					18. throws objects	#		
5. screams	#					19. tears	#		
6. whines	#					20. breaks	#		
7. swears	#					21. inappropriate facial expressions	#		
8. insults	#					22. inappropriate gestures towards others	#		
9. threatens	#					23. tantrums	#		
10. lies	#					24. leaves assigned area	#		
11. bosses	#					25. mouths objects ³¹	#		
12. complains	#					26. self-stimulatory behavior	#		
13. talks to self ³⁰	#					27. removes clothes inappropriately	#		
14. inappropriate vocalizations	#					28. inappropriate treatment of excretions	#		
# additional IEP objectives	#					# additional IEP objectives	#		
SET	MASTERED	MASTERED	MASTERED	MASTERED	SET	MASTERED	MASTERED	MASTERED	MASTERED

Figure 4.8 Specific Inappropriate Behavior Checklist

Inventory for Ages 3-6

I. PROVISION OF STIMULATION THROUGH EQUIPMENT, TOYS, AND EXPERIENCES.		YES	NO
1-12	The following are present in home and either belong to child subject or he is allowed to play with them:		
1.	Toys to learn colors, sizes, shapes -- toy typewriter, pressouts, play school, peg boards, etc.		✓
2.	Toy or game facilitating learning letters (e.g., blocks with letters, toy typewriter, letter sticks, books about letters, etc.)		✓
3.	Three or more puzzles.		✓
4.	Two toys necessitating some finger and whole hand movement (crayons and coloring books, paper dolls, etc.)	✓	
5.	Record player and at least five children's records.		✓
6.	Real or toy musical instrument (piano, drum, toy xylophone or guitar, etc.)		✓
7.	Toy or game permitting free expression (finger paints, play dough, crayons or paint and paper, etc.)		✓
8.	Toys or game necessitating refined movements (paint by number, dot book, paper dolls, crayons and coloring books.)		✓
9.	Toys to learn animals -- books about animals, circus games, animals puzzles, etc.	✓	
10.	Toy or game facilitating learning numbers (e.g., blocks with numbers, books about numbers, games with numbers, etc.)		✓
11.	Building toys (blocks, tinker toys, Lincoln blocks, Lego, etc.)	✓	
12.	Ten children's books.	✓	
13.	At least ten books are present and visible in the apartment.	✓	
14.	Family buys a newspaper daily and reads it.	✓	

Figure 4.9 Home Observation for the Measurement of the Environment

special education specialist prior to or following the completion of the functional skills assessment.

5. Baseline and prescriptive teaching data are recorded by ~~some~~ parents as part of the Family Education Program (Figure 4.10).
6. A diagnostic evaluation using professionals trained in disciplines related to the areas of deficits is scheduled. Every attempt should be made to involve local professionals in the diagnostic evaluation. If local professionals are unavailable to conduct the diagnostic evaluation, nearby services may be tapped. In cases where the child is referred with a diagnosis or a recent evaluation, scheduling another such evaluation is generally unnecessary. Also if no delays are noted during screening but a number of professionals believe the child is at-risk of requiring special education services during the school years, the program planned will focus on helping the parents appropriately stimulate the child. In this case a diagnostic evaluation of the child may also be unnecessary.

The purpose of the screening is to identify those children who appear to be delayed in such a way that a more in-depth evaluation is warranted. It also helps to identify the areas of deficit to be assessed during the functional skills assessment.

Family Education Program (FEP)

Child's Name John Doe

Date 12-22-78

Home Visitor Diane Smith

Supervisor Ann Murray

General Objective	Specific Objectives*	Date Objective Discussed With Family
1. To increase parents' knowledge of normal child development patterns. 2. To increase parents' knowledge of their child's handicapping condition and of handicaps in general. 3. To increase parents' understanding of desirable parenting and child-rearing practices. 4. To facilitate parent and family adjustment to the handicapped child. 5. To increase parents' knowledge of available community and governmental resources which could help the family cope. 6. To aid parents in observing and collecting data regarding their child's behavioral performance. 7. To increase parents' teaching skills. 8. Other	6.1 Jim and Mary will record the daily toilet training information on the toilet training chart.	

*Circled items indicate those educational objectives identified by the parents for themselves and recorded on the IIP.

Home Visitor: Diane Smith

Supervisor: Ann Murray

Signatures

12/22/78

Date

12/22/78
Date

Figure 4.10 Family Education Program

The purpose of the skills assessment is to pinpoint those skills which have been mastered and those which are yet to be learned so that appropriate placement within the curriculum can be determined. The parent-child interaction assessment helps to identify which skills the parents may need in order to become more effective teachers of their own child. In addition it helps the staff to get a picture of the child's world from the child's perspective.

The purpose for administering an Alpern-Boll Developmental Profile is simply to provide some data to external program evaluators of the success of the Project Sunrise model and in no way is meant to make a judgment about the child's intelligence. The diagnostic evaluation is necessary in order to obtain input from a team of professionals representing several different disciplines so that an appropriate Individualized Educational Plan can be written.

The administration of the HOME aids in development of the Family Education Program (FEP, Figure 4.11). Objectives can be developed which in part teach the parents skills to be used in an ongoing assessment of their own child. When an evaluation by the interdisciplinary professional team can be scheduled, the parent then has baseline data and/or prescriptive/diagnostic teaching data to contribute to the pool of information about the child. In this way, the parents become more objective observers of their own child and are able to contribute as equal team partners to the entire process, rather than being passive recipients of a diagnosis handed down by the "experts."

Family Education Program (FEP)

Child's Name John Doe

Date 12/22/78

Home Visitor Diane Smith

Supervisor Ann Murray

General Objective	Specific Objectives*	Date Objective Discussed With Family
1. To increase parents' knowledge of normal child development patterns.		
2. To increase parents' knowledge of their child's handicapping condition and of handicaps in general.	2.1 Mary will view filmstrips and read information related to the education of the mentally retarded.	12-16-78
3. To increase parents' understanding of desirable parenting and child-rearing practices.		
4. To facilitate parent and family adjustment to the handicapped child.		
5. To increase parents' knowledge of available community and governmental resources which could help the family cope.	5.1 Mary & Jim will apply for respite care services for John.	12-14-78 12-14-78
6. To aid parents in observing and collecting data regarding their child's behavioral performance.	6.1 Jim and Mary will record daily toilet training information on the toilet training chart.	12-22-78
7. To increase parents' teaching skills.	7.1 John and Mary will provide appropriate cues and consequences during the toilet training program.	12-22-78
8. Other		

*Circled items indicate those educational objectives identified by the parents for themselves and recorded on the IIP.

Home Visitor: Diane Smith

12/22/78

Supervisor: Ann Murray
Signatures

Date
12/22/78
Date

Figure 4.11 Family Education Program

Involving the parents in the evaluation process in this manner also has the advantage of permitting everyone involved to see the child's average performance over several weeks as opposed to a "one-time shot." If children are diagnosed on the basis of only one day's performance, there is always the chance that they may be performing less than optimally due to illness, fatigue or emotional upset. The observations and pre-scriptive teaching data which the parents collect during the FEP permit a more reliable evaluation.

In some cases the experiences provided during the FEP may be necessary in order for a diagnostic evaluation to be conducted. If the child has severe behavior problems or an extremely short attention span, it may be impossible to keep him on-task in order to do an evaluation. In this case, the FEP might include a behavior management program to prepare the child for an inter-disciplinary evaluation.

Program Planning

Following the administration of the Alpern-Boll Developmental Profile, the home visitor and early childhood special education specialist meet to write a temporary Individualized Instructional Plan (IIP, Figure 4.12). The should include educational objectives which the parents have identified for themselves or other family members. It is important for the staff to encourage the parents to jointly share in the planning of the child's program.

PROJECT SUNRISE
INDIVIDUAL INSTRUCTIONAL PLAN
Short Term Objectives

Name John Doe Date of Birth 10-7-74 Program Date 2-28-78

COGNITIVE	LANGUAGE
	1. John will be able to indicate his need to use the word "potty" 2/3 times by 1/31/79
SELF HELP	SOCIAL
1. John will be able to use the toilet correctly 90% of the time by 3/1/79.	

117

118

Figure 4.12. Temporary Individualized Instructional Plan

Name John Doe

GROSS MOTOR

FINE MOTOR

105

FEP Objectives which the parents have identified for themselves and other family members

Mary will view filmstrips and read information related to the education of the mentally retarded handicapped and/or Down's Syndrome children.

Following the interdisciplinary diagnostic evaluation the Child Study Team (CST) officially meets to write the Individualized Educational Plan (IEP, Figure 4.13). The CST is comprised of the parents, the home visitor, the early childhood special education specialist and any other individuals responsible for implementing an appropriate educational program for the child (e.g., Head Start or preschool teacher, babysitter or speech therapist). Once the annual, long-range goals of the IEP are developed, the parents should be given the opportunity to priority rank those goals so that they may be more willing to implement the instructional activities. One part of the IEP is the IIP which outlines the quarterly objectives for the child. A new IIP is written quarterly to help assure that the annual goals identified on the IEP are reached.

Referral may be made at anytime to a more appropriate service agency. For example, if a blind or deaf child is identified, that child may be referred immediately to the Montana School for the Deaf and Blind Outreach Program. If the family lives within a school district which has a speech clinician, referral of a child with an articulation disorder will be made to that district. In some cases, an inter-agency decision may be made to provide joint services to the child and family. Each case should, however, be reviewed on its own merits, and the unique needs of each family considered individually. In addition, each agency involved will need to consider the strengths and weaknesses of its staff, its

**PROJECT SUNRISE
INDIVIDUAL EDUCATIONAL PROGRAM**

Functional Level: Alpern-Boll Developmental Profile - 2-6 yrs.

Name John Doe
B/D 10-7-74
R/D 12-2-78
E/D 4-10-79

Eval. Through Montana Center for Handicapped Children

Specific Deficits:

John's receptive language skills indicate functioning at about 3.0 years; however, his expressive language skills indicate functioning at about 18 month level.

Specific Strengths:

John responds well to other people and enjoys the attention of his parents and grandmother.

Priority Ranking Annual Goal	Evaluation Procedures for each Annual Goal Statement	Agency or Individual Responsible for Annual Assessment
1. To increase John's feeding and dressing skills	1.1 CAMS - self help portion	1.1 Project Sunrise home visitor
2. To increase John's expressive language skills.	2.1 UPAS - expressive language portion	2.1 Project Sunrise Home Visitor
3. To increase John's balance and mobility skills.	3.1 Reassessment by O.T. and P.T. Readministration of Alpern-Boll	3.1 O.T. and P.T at Montana Center for Handicapped Children. Project Sunrise early childhood special education specialist.

Specific Procedures/Materials, etc.	Starting Date	Ending Date	Data
1.1 CAMS Self-Help Program	1.1 4-17-79	to 4-17-80	1.1. CAMS assessment indicate feeding skills at 10 mos. and dressing skills at 14 months.
2.1 Teaching Research Initial Expressive Language Program and communicative interaction techniques	2.1 5-5-79	to 4-17-80	2.1 Names 21 objects, says "Daddy go bye-bye" and "Danny go school No other three word phrases.
3.1 CAMS Motor Program	6-15-79	to 4-17-80	3.1 CAMS assessment indicates fine motor skills at 15 months and gross motor skills at 18 months

Child Study Team Signatures:

PROJECT SUNRISE
INDIVIDUAL EDUCATIONAL PROGRAM
Short Term Objectives

Name _____ Date of Birth _____ Program Date _____

COGNITIVE

LANGUAGE

- 2.1 John will be able to name an additional 20 objects by 7/17/79.

SELF HELP

SOCIAL

- 1.1 John will be able to hold a glass in both hands and drink by 7/17/79.
- 1.2 John will be able to eat with a fork in his fist by 7/17/79.

124

125

Figure 4.13 Continued

108

Name _____

GROSS MOTOR

FINE MOTOR

FEP Objectives which the parents have identified for themselves and other family members

Jim and Mary will join a parent group for parents of handicapped children.

126

127

geographic location, and its ability to deliver services to the family.

Program Implementation

Following the development of an Individualized Educational Plan and the Individualized Instructional Plan, the child's program is implemented. The home program is monitored by the home visitor under the supervision of the Project Sunrise center staff. The actual teaching, however, is done by the parents or the primary caregiver who could be a babysitter, grandparent or older sibling. Even when the activities are presented by another caregiver, every effort must be made to place the ultimate responsibility upon the parents or those adults who will have the most long-term involvement with the child throughout life. The specialist is responsible for coordinating the home program with services provided by other agencies, such as a preschool, speech clinician or public health nurse.

The Individualized Instructional Plan (IIP) specifies the short range goals to be mastered by the child within a twelve-week (three month) period. It is developed from the IEP and becomes a part of the IEP. These IIP objectives are then translated into activities which the home visitor models for the parents during their weekly sessions. These activities should be structured in sufficiently small steps that the week's objective is mastered prior to the next home visit.

The IEP and quarterly IIP are prepared by the early childhood special education specialist following the CST planning meeting. The IIP is then task analyzed and weekly lesson plans are developed by the home visitor in conjunction with the center aide or the early childhood special education specialist. Depending upon the competencies and experience of the home visitor, it may be necessary for the weekly lesson plans to be written primarily by the center aide or the specialist.

Program Reassessment

A functional skills assessment is readministered quarterly by the home visitor in those areas in which instruction has been and/or immediately will be provided. The results are given to the early childhood special education specialist and a new IIP is written. In addition, weekly data collected by the home visitor is transmitted via telephone to the center aide so that the specialist is able to constantly monitor the child's program and changes can be made prior to the next home visit. The Alpern-Boll Developmental Profile is readministered annually to the child to help assess total program effectiveness.

The Curriculum

The five areas which comprise the curriculum for the pre-schoolers are motor (gross and fine), communication, pre-academic, self-help and social-emotional areas.

The basic curriculum adopted for use by Project Sunrise is

The Curriculum Assessment and Monitoring System (CAMS), developed by the Exceptional Child Center, Utah State University, Logan, Utah, and available from Demco Educational Corporation, DeForest, Wisconsin 53532.

The following reasons explain why this curriculum was adopted for use in implementing this model:

1. The curriculum is comprehensive and covers the five basic areas identified for inclusion in the young child's curriculum. (Preacademic skills are included with the motor and language portions).
2. It was developed for use with paraprofessionals working in home-based programs. The pages can be zeroxed and given to families so that weekly data may be recorded.
3. An accompanying slide-tape presentation has been developed for training paraprofessionals in the use of the CAMS.
4. It employs a structured, behavioral approach to teaching.

It was felt that the CAMS expressive language program would be extremely difficult to administer. Therefore this portion of the curriculum was omitted. Assessment of expressive language will be based upon the expressive language portion of the UPAS.

The parents are taught how to facilitate communicative interaction (Reike, 1977) to elicit language from their child. The analysis of the 50-utterance language sample for children with deficits in expressive language will result in programming recommendations by the speech clinician.

Even in areas other than expressive language, it may be necessary to supplement the CAMS with other curricula. This is particularly true if the program is designed primarily to provide stimulation or to effect a decrease in inappropriate behaviors. A bibliography of supplementary materials which may be tapped in addition to the CAMS is included in Appendix B. Whenever such materials are recommended for use with a child, it is the responsibility of the early childhood special education specialist to assure that the home visitor knows how to use the material effectively. Regardless of the material selected, the approach that the parents use in working with the child is always behavioral. The cue (antecedent) reflects what the parents do, the behavior reflects what the child does, and the consequence is what the parents do in response to their child's behavior.

SUMMARY

Project Sunrise services to children include identification, screening, a functional assessment of skill strengths and weaknesses, planning the diagnostic evaluation which is conducted by an interdisciplinary team, program planning, program implementation, and program reassessment. An important part of the entire assessment/evaluation process is the parents' role in collecting baseline and/or prescriptive teaching data as part of the Family Education Program (FEP). Diagnostic evaluations and program planning should reflect a team effort. The parents serve as members

of both the evaluation team and the Child Study Team. The parents also hold the responsibility of prioritizing the annual goals on the IEP.

The curriculum into which a child is generally programmed is The Curriculum Assessment and Monitoring System (CAMS). The parents are taught how to use communicative interaction techniques to stimulate expressive language. Deficits in the area of expressive language necessitate the tape recording of a 50-utterance language sample to be analyzed by a speech clinician. Specific programming recommendations can then be made by the consultant speech clinician.

It may be necessary to supplement the CAMS with other curricula, especially if the program is designed to help the parents provide a more stimulating environment for the child or if the purpose is to decrease the child's inappropriate behaviors. Regardless of the curriculum used, the approach to teaching the child is always behavioral and emphasizes the cues and consequences provided by the parents.

Chapter 5
THE PARENTS

In the Project Sunrise model the focus of the home visit is always upon the parent rather than the child. It is the parent who is responsible for the daily implementation of the teaching activities with their youngster. In order to do this they must acquire some of the skills needed to be an effective teacher. During the weekly visit to the home, the home visitor concentrates on helping the parents provide more effective cues and consequences to their child.

In order for the child to receive the most effective services possible through the Project Sunrise model, the parents have the following responsibilities.

A. Referral

1. To refer their child to Project Sunrise by:
 - a) telephone, or
 - b) mailing in the appropriate section of the referral form, or
 - c) signing the agency referral form acknowledging that the referral is being made by that agency (optional).

(The responsibility of referral is optional since a referral may be made by anyone who feels the child has a problem. It

is, however, advantageous if the parents make or acknowledge the referral since this implies some degree of adjustment to the child's problem.)

B. Screening

1. To permit the administration of a screening procedure such as the DDST, to be administered by a Project Sunrise staff member and to observe or participate in that screening, if asked.

C. Assessment

1. To sign the Parental Permit to Evaluate Form giving permission for Project Sunrise staff members to conduct the assessment procedure.

a) Child assessment in areas of deficits

- 1) CAMS - motor, self-help and social-emotional portions.
- 2) UPAS - preacademic and communication portions and/or the Inappropriate Behavior Checklist

b) Parent-child interaction assessment using Bettye Caldwell's Home Observation for the Measurement of The Environment. (HOME).

c) The Alpern-Boll Developmental Profile

D. Family Education Program (FEP)

1. To provide suggestions for goals and objectives to be

be included in the Family Education Program. Input might include:

- a) Needs for the child as identified by the family on the temporary IIP.
- b) Needs of the parents and siblings to better understand and cope with the child and the handicapping conditions to be included in the FEP.

2. To participate in educational activities related to the Family Education Program (FEP).

E. Child Diagnostic Evaluation

1. To provide suggestions to the Project Sunrise staff regarding whom they would prefer to have conduct the interdisciplinary diagnostic evaluation, and where and when they would like it done.
2. To sign the necessary permission forms and assure that the child keeps scheduled appointments for the diagnostic evaluation. Whenever possible, the parents should observe the evaluation procedures.
3. To participate in the evaluation team meetings by collecting and/or presenting prescriptive teaching data and by asking questions during the meeting.
4. To give written permission to release the results of the interdisciplinary evaluation to Project Sunrise.

F. Program Implementation

1. To keep appointments with the home visitor, and complete weekly teaching assignments.
 - a) To implement teaching activities with the child at least five out of seven days each week and in the presence of the home visitor during the following week's visit.
 - b) To observe the new teaching activities as demonstrated by the home visitor and to implement those procedures in the presence of the home visitor.
 - c) Upon request, to keep data during the week and communicate that data to the home visitor by telephone or during the next weekly home visit.
 - d) To provide the center staff with requested information regarding satisfaction with the program services and the performance of the home visitor either in person, by mail or by phone.

H. Program Evaluation

1. To permit quarterly reassessments of the child.
2. To give written evaluation to permit photographing and videotaping of assessment and training activities.
3. To give written permission for Project Sunrise to release information from their child's file to other agencies or individuals.

PROJECT SUNRISE

Photograph and Film Release Form

☐

I, _____, hereby grant permission to Project Sunrise to photograph and/or film during actual or simulated training, the following: _____

☐

I do not grant permission to film and/or photograph the following: _____

☒

I, James Doe, grant permission to Project Sunrise to use these films and/or photographs in public presentations by Project Sunrise.

☐

I, _____, grant permission to Project Sunrise to use films and/or photographs only for the purpose of planning an appropriate family program.

James Doe
Parent's Signature

12/22/78
Date

Anne Perry
Project Sunrise Representative

12/22/78
Date

These responsibilities are summarized in the following role description.

In order to implement the Project Sunrise Model, the role of the parents is:

1. To permit and participate in referral, screening, assessment and evaluation of the child.
2. To permit and participate in the parent-child interaction assessment.
3. To aid in developing the objectives for the Family Education Program (FEP) and the child's Individualized Educational Plan (IEP).
4. To give written permission for assessment and evaluation procedures, for photographing or videotaping the child and/or family, and for releasing information from and to Project Sunrise.
5. To participate in FEP activities and to implement the child's weekly lesson plans which were demonstrated by the home visitor at least five days out of seven days each week.
6. To complete the necessary forms related to intake of the child into the program and to the evaluation of the program.

PROJECT SUNRISE

Photograph and Film Release Form

 X I, James Doe, hereby grant permission to Project Sunrise
to photograph and/or film during actual/simulated training, and
screening/assessment/evaluation procedures.

 I do not grant permission to film and/or photograph my child.

The following:

 X I, James Doe, grant permission to Project Sunrise to use
these films and/or photographs in public presentations by Project Sunrise.

 I, _____, grant permission to Project Sunrise to use
films and/or photographs only for the purpose of planning an appropriate
family program.

James Doe
Parent's Signature

12/28/78
Date

Ann Murray
Project Sunrise Representative

12/28/78
Date

Figure 5.1 Photograph and Film Release

PROJECT SUNRISE
CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

I hereby give permission for a mutual exchange of any and all
information regarding history, diagnostic and treatment records
and similar information between Project Sunrise and _____
The Montana Center for Handicapped Children

From the records of:

John Doe Birth date: 10/7/74
(Name of Client)

James Doe
(Name of Person giving Consent and Date)

Ann Murray - 12/24/78
(Sunrise Representative and Date)

Figure 5.2 Consent for Mutual Exchange of Information Form

The Family Education Program

The purpose of the Family Education Program (FEP) is to help the home visitor and the supervisor plan for appropriate teaching strategies to use during the home visits. The primary prerequisite to begin implementing any teaching activities with the child is the writing of the objectives for the FEP. These objectives are written following the completion of the assessment procedure.

The use of the HOME aids the staff in determining to what degree the home is child-centered rather than adult-centered and how effective the parents are at creating a stimulating yet structured learning environment for their child. This assessment plus informal observations aid the home visitor and supervisor in selecting appropriate educational objectives for the FEP. In addition to writing the IIP for the child, the parents identify educational objectives which they have for themselves. These objectives are recorded on the FEP and circled to designate their high priority.

FEP objectives should be tailored to the needs of each individual family; however, these seven areas are considered general objectives to be examined for possible inclusion:

1. To increase parents' knowledge of normal child development patterns.
2. To increase parents' knowledge of their child's handicapping condition and handicaps in general.

3. To increase parent's understanding of desirable parenting and child-rearing practices.
4. To facilitate parent and family adjustment to the handicapped child.
5. To increase parents' knowledge of available community and governmental resources which could help the family cope.
6. To aid parents in observing and collecting data regarding their child's behavior performance.
7. To increase parents' teaching skills.

Each general objective can be further defined, and those objectives selected for inclusion in the Family Education Program can be recorded on the FEP (Figure 4.10).

Examples of specific objectives for each general objective include the following:

1. To increase the parents' knowledge of normal motor development of children birth to one-year-old.
2. To increase the parents' knowledge of Down's Syndrome.

3. To increase the parents' understanding of desirable parenting and child rearing practices.
4. To facilitate parent and family adjustment to the handicapped child.
5. To increase the parents' use of appropriate cues and consequences while teaching their child to correctly match six color cards (blue, yellow and red).
6. To increase the parents' observational techniques so that they are better able to identify cues and consequences which trigger and maintain their child's inappropriate behavior.
7. To teach the parents to record their observations of child performance.
8. To support the parents and enhance their adjustment to the handicapping condition.

The purpose of the FEP objective is to aid in structuring and planning for subsequent home visits and for bringing appropriate materials into the home. These objectives should focus primarily on changing parent behaviors; however, they may include objectives related to changing sibling behaviors. If a handicapping condition is suspected, a major objective will be to aid the parents in permitting and arranging for the interdisciplinary evaluation. Whether or not such an evaluation has been completed, at least one objective will generally deal with teaching the parent to take baseline or observational data. If the diagnostic evaluation has

not yet been completed, the parent may be asked to share this with the evaluation team. If the evaluation was done prior to referral, this data may be necessary to implement teaching activities.

As part of the FEP the parent may be taught how to teach their child skills in any area of the child's curriculum so that diagnostic/prescriptive teaching data is available. These teaching activities must be carefully chosen, however, because a formal evaluation of the child may not yet have been conducted. Consequently the early childhood special education specialist must monitor the FEP closely, and parental wishes regarding the child must be taken seriously.

Options for Parental Involvement

Not all parents will be able to participate on the same level, nor should the same degree of parental involvement be expected for every family. For this reason options for parental involvement should be provided.

Parents as Primary Teachers

The optimum type of parent involvement for a home-based program is for the parents to become effective teachers of their child so that the child quickly and efficiently learns the specified skills. This requires that parents learn to capitalize on their child's curiosity and take advantage of natural learning situations that occur each day. Most importantly for the handicapped child the parents need to learn how to structure an optimum teaching situation

so that cues and consequences can be systematically presented.

Ideally daily performance data will also be recorded by the parents.

Depending upon parental skills and abilities, the Project Sunrise staff will need to individualize activities for the parents. Some parents will be able to structure a learning session with their child but may be unable to capitalize upon the more informal opportunities which arise. Some parents may be unwilling to take daily performance data, regardless of how simple the procedure may be. In this case, the home visitor will simply observe the teaching activity assigned for the previous week and take post-teaching data which can be compared to the pre-teaching data in order to make program decisions.

Some, but certainly not all parents will be able to make teaching games and materials for use with their child. When time is at a premium it may be advisable to encourage the parents to spend their time working with the child rather than making instructional materials.

Parents as Support Teachers

In some cases a primary caregiver in addition to the parents will be trained in presenting the teaching activities. Especially when both parents work full-time and the child spends most of the waking hours with a babysitter, relative, or daycare provider, both the caregiver and the parents should be trained. In this case, the primary caregiver might be responsible for implementing the program activities during the hours when the child is most

playful and cooperative. The parents would be responsible for helping to generalize the new skill to other situations and for practicing the skills at home. The responsibility for the child's total development must lie clearly with the parents since their involvement is more sustained and long-lasting than that provided by other caregivers. Even in these cases the Family Education Program (FEP) should be planned and implemented in the same way that it is when the parents serve as primary teachers.

Parents as Program Support Personnel

Whenever possible parents should be used to provide input to the program and its development. All parents served should be requested to provide feedback regarding their satisfaction with services received and with program satisfaction. This information should be used to make program adjustments and to make changes in child and family services. In addition a limited number of interested parents will be asked to serve as representatives on the advisory board.

Some parents might be willing to become community resources for new families just entering the program. They might accompany the home visitor to become better acquainted with an incoming family and provide the parents with additional information about Project Sunrise. Together they might form a mutual support system to help one another through the inevitable crises that every family seems to face.

Parents with special talents and interests might be willing to donate their efforts to meet a special need of the project. For example, someone with sewing, artistic or woodworking skills might be willing to provide special equipment or materials needed at one of the demonstration sites.

Parents as Program Advocates

In addition some parents might be willing to be advocates for child services within their community or even on a broader scope. In this capacity they might be willing to speak to service organizations or agencies in support of identification and screening programs as well as direct services for handicapped children. Interested parents could be instrumental in presenting the necessary testimony to assure continued funding of the program. Letters or personal appearances might be required . at the state, county, or local level to assure program continuation. In this case their willingness to serve as program advocates would be invaluable.

Parents As Paraprofessional Home Visitors

Some parents may be willing to "graduate" from being recipients of the service to being providers. In this case, they would be required to take the paraprofessional training. The advantage of this would be that they would have the experience of having worked with their own handicapped child and might be better able to relate to the parents whom they are serving.

Parent Competencies

In order to implement an Individual Instructional Program (IIP), and the accompanying weekly activities with their handicapped child, a parent needs to possess the following minimal competencies:

1. To correctly cue the child using appropriate verbal and and non-verbal antecedents (cues).
2. To correctly identify the target behavior (know whether or not the child has met the criterion).
3. To correctly consequent the behavior
 - a) if the behavior met criterion.
 - b) if the behavior did not meet criterion.
4. To correctly record the necessary data and complete the required program forms.
5. To provide appropriate learning materials and an appropriate learning environment for the child.

It is the responsibility of the Project Sunrise staff to assure that the parent has these skills for teaching their child. The home visitor and the early childhood special education specialist may need to find numerous ways to individualize so that each parent is able to acquire these minimal skills.

Much of the success of Project Sunrise in achieving child progress rests with the parents and their ability and motivation for implementing the child's weekly activities. It is the

responsibility of the Project Sunrise staff to assure that they have the opportunity to develop the skills required for teaching their handicapped child.

SUMMARY

The parent teaching required by this model relies heavily on a behavioral philosophy. Parental responsibility for implementing the model from screening to evaluation is great. Ultimately all decisions regarding the child belong to the parents, and every professional involved with the family must respect their right to make decisions regarding their child.

The Family Education Program (FEP) is designed to meet parental and family needs regarding their handicapped child. Objectives may be written to meet needs for knowledge, attitude change or skills. The parents are generally asked to take baseline and/or prescriptive teaching data as part of the foundation of information needed by the evaluation team.

The focus of the home visit is always upon the parents rather than the child. The home visitor is responsible for providing the parents with the skills necessary to implement behavioral teaching techniques. Special emphasis is placed upon the parents' appropriate use of cues and consequences.

Parental involvement can take place on several different levels. Parents can be primary or support teachers to their child. They can be program support personnel or program advocates. Some may even go on to become paraprofessional home visitors within the program.

Chapter 6

THE PARAPROFESSIONAL HOME VISITOR

The purpose of the paraprofessional home visitor is to serve in a helping relationship as the teacher (educational change agent) and informal peer counselor to the parent. The home visitor's weekly visit to the home provides the opportunity to implement the activities related to the objectives for the family and the child. In addition, it is during this weekly home visit that materials are exchanged, family problems may be discussed and plans are made for future visits.

It is paramount that the home visitors at all times be aware of both their responsibilities and limitations, since the temptation may often be strong to play a professional rather than a paraprofessional role. Although home visitors may be professionals in nursing, social work or regular education, they generally are paraprofessionals to the field of special education. As paraprofessionals they must be aware that programming decisions affecting the handicapped child are legally the responsibility of the early childhood special education specialist. Their responsibility is to carry out those decisions by assuring that the parents understand and are motivated to implement the activities on the weekly lesson plan.

Responsibilities of the Home Visitor

The following responsibilities comprise the duties of the paraprofessional home visitor in implementing the Project Sunrise Model:

A. Identification (Child Find)

1. To informally or formally (upon assignment from the early childhood special education specialist) help to inform their community of Project Sunrise services.
2. To put concerned parents or others in contact with the center staff.
3. To aid in the distribution of Project Sunrise brochures or other media releases.

B. Screening

1. To administer the screening instrument (DDST or CIP) in the presence of the specialist during the first home visit or as soon as parents give permission. (Screening is generally unnecessary if the child has had a previous screening or diagnostic evaluation).

C. Assessment

1. To inform parents of their rights and obtain their signature(s) on the Due Process Form and Parental Consent Form.
2. To administer a functional skills assessment in the areas of deficits where programming will take place. The CAMS assessment should be used for motor, self-help and social-emotional skills and the UPAS assessment should be used in the area of pre-academic skills and communication skills. It may also be necessary to complete the UPAS

Inappropriate Behavior Checklist if the child's behavior is a concern to the parents or others. The entire assessment will take place at one or more home visits subsequent to the screening which indicates eligibility. The assessment process should be completed within about a week of the temporary eligibility decision. Prior to administering any assessment instruments the parents must have signed the Parental Consent to Evaluate Form.

3. To complete the Home Observation for Measurement of the Environment by the time that the functional skills assessment is complete.
4. To facilitate the tape recording of a 50-utterance language sample to be submitted for analysis by a speech therapist when language delays are noted.
5. To observe the administration of the Alpern-Boll Developmental Profile when it is administered by the early childhood special education specialists.
6. To aid the parents and specialists in developing the child's temporary Individualized Instructional Plan (IIP).

D. Family Education Program (FEP)

1. To make recommendations for objectives to be included on the FEP and to aid the specialist in writing the FEP plan.

2. To provide educational materials appropriate to the objectives of the FEP to the family during the home visits.
3. To maintain a separate file folder containing the FEP's for all families which the home visitor serves.
4. To provide recommendations to the parents for increasing the child's skill level during home visits in accordance with the objectives outlined on the temporary IIP.
5. To provide suggestions for better parenting to the parents during home visits.
6. To emphasize the cue-behavior-consequence behavioral pattern with the parents during weekly home visits.

E. Child Diagnostic Evaluation

1. To observe the professional diagnostic evaluation of the child, if possible.
2. To participate in the evaluation team meeting by:
 - a. Accompanying parents, if requested.
 - b. Contributing observational or other data, if requested.
 - c. Listening to the information presented to aid in future planning for the child.
3. In cases where the decision whether to continue to participate in future Project Sunrise services is not made at the time of the evaluation team meeting, the

home visitor will be responsible for:

- a. obtaining the parental decision about whether to continue the program.
- b. communicating that decision to the center staff.

F. Program Planning (Writing the Individualized Educational Plan)

1. To participate in the Child Study Team (CST) meeting at which the annual goals and objectives are outlined.
2. Following the completion of the IEP and IIP by the center staff, it will be a the home visitor's responsibility:
 - a. To provide suggestions for weekly lesson plans, or
 - b. To write the weekly lesson plans on assignments.

G. Program Implementation

1. To prepare and deliver materials for both the IEP and FEP to the home.
2. To explain and demonstrate the weekly lesson plan for the parents.
3. To observe the parents conducting the weekly lesson plan with the child .
4. To provide feedback to the parents on their teaching performance during the home visit, especially cues and consequences provided in teaching their child.

H. Program Evaluation

1. To collect daily child data from parents, whenever such data has been assigned.
2. To collect pre- and post-teaching data by observing the parents as they implement the weekly lesson plan from the previous week.
3. To communicate child progress data to the center aide or specialist during the weekly phone call and by mailing in a Home Visit Report Form (Figure 6.1) to the center staff as requested by the supervisor.
4. To readminister appropriate portions of the CAMS and UPAS to the child on a quarterly basis.

Other responsibilities which the home visitors have include:

1. To always protect the family's right to confidentiality.
2. To report suspected cases of child abuse or neglect both to the supervisor and the appropriate authorities.
3. To submit all requested forms and information required for implementing this model.
4. To participate fully in in-service training sessions and supervisory conferences.

Qualifications of the Home Visitor

Since pre-service and in-service training time is limited, the more helper traits a trainee demonstrates prior to the training, the more competencies he or she will be able to master by the

PROJECT SUNRISE
Home Visit Report

Miles Traveled _____

Child's Name John Doe

Date 1-22-79

Persons trained: Mary Doe and Susan Brown

Time: 1:30 to 2:30

Others present: Danny

Home Visitor Diane Smith

I. Purpose of Home Visit:

Supervisor: Ann Murray

Screening _____ Assessment _____ FEP Activities x IIP Activities x Re-Eval. _____
Other _____

II. Family Education Program (FEP)

Objective (s): To discuss the reason for early education of Down's Syndrome children

Activities: Show and discuss filmstrip

Materials: Concept media filmstrip and cassette tape "Risk Factors," filmstrip viewer and cassette player.

Results: Both Mary and Susan asked a number of questions related to one filmstrip

III. Child's Lesson Plan (IIP)

Post Training Data: Criteria (4 yeses in five trials) met on the fifth day of the program

CAMS For T-35-1 Self Help T35-2 Other _____
Area - Level - Step _____ Program - Area - Level _____

New Lesson Plan:

CAMS For T35-1 Self Help T35-2 Other _____
Area - Level - Step _____ Program - Area - Level _____

1. Materials needed: Bites of cereal
2. Cue - Verbal: "Do you need to go potty?"
- Non-verbal
3. Behavior: Child sits on potty for five minutes
4. Consequence - If correct: Praise and give him a bite of cereal every 30 seconds
If incorrect: After five minutes remove him from potty and praise him for sitting quietly.
5. Record Keeping Procedures CAMS record sheet T 35
6. Pre-training data: During home visit sat on potty 6½ minutes with a bite of cereal every 30 seconds

IV. Obligations to family to be completed prior to or during next home visit:
Contact Developmental Disabilities for a respite care application.

V. Problems Reported by Family

Clarification was needed so that all family members put John on the potty only at times he is not likely to defecate. This procedure should be used until Step 6 of Objective T35.

completion of the training. For this reason paraprofessional home visitors exhibiting the following characteristics and qualifications, will be sought. The home visitor needs:

1. Background in social work, education, nursing or related human services fields (optional).
2. The ability to listen actively to others when participating in small group or individual conversations.
3. The ability to express ideas to other adults in individual or small group settings.
4. The ability to communicate with and respond to the needs of young children.
5. To demonstrate acceptance of individuals as valuable regardless of race, religion, sex, age, handicap or social background.
6. A high regard for professional ethics, especially in the area of confidentiality.
7. A perception of people as being dependable, friendly and worthy.
8. Problem solving ability.
9. Dependability in situations where he or she must work with little supervision.
10. Transportation for weekly home visits.

Selection and Hiring

Prior to beginning a recruitment program to hire paraprofessional home visitors, several decisions must be made. The number

of home visitors to be hired for each early childhood special education specialist on staff must be designated. It is believed that each specialist is capable of supervising between five and eight paraprofessional home visitors depending on the distances and conditions of the roads, the number of families each home visitor is serving, the skill and experience of the home visitor and the number and quality of back-up resources available in each of the communities served. Attempts should be made to locate a paraprofessional home visitor in communities where a large number of target children are located or within commuting distance of a number of families scattered over a fairly wide geographic area (a radius of about 50 miles). Priority should be given to those communities which indicate the greatest need and a willingness to support and back a paraprofessional home visitor.

Once the decision is made regarding how many paraprofessional home visitors are to be hired and where they are to be located, recruitment procedures can begin. These efforts are directed toward obtaining the most suitable applicants for each home visitor position. With effective recruitment efforts it may be possible to locate applicants who are actually professionals in other fields, such as nursing, education or social work, but who are presently desiring part-time work.

Procedures for recruitment might include the following:

1. Placing help-wanted ads in local newspapers

2. Requesting recommendations for potential applicants from professionals within the community, from local child care providers, or from parents who have handicapped children.
3. Distributing posters and flyers.
4. Asking people to apply during public speaking opportunities.
5. Using mass media public service announcements.

All hiring procedures should be in keeping with Equal Employment Opportunity (EEO) guidelines for hiring practices.

An applicant first submits an application form (Figure 6.2) to the program coordinator. The coordinator reviews the application forms and passes them on to the appropriate early childhood special education specialist. The specialist responsible for each trainee position then contacts all references listed by the applicants for that position. Based on the written application and the recommendations of the references, the specialist then selects the top applicants for each position to interview. The early childhood special education specialists and coordinator together interview these applicants using the Home Visitor Interview Guidelines (Figure 6.3). Separately each interviewer completes a Home Visitor Applicant Ranking Scale (Figure 6.4). From this ranking procedure the specialist then offers a Home Visitor Training Agreement (Figure 6.5) to the top applicant to be signed and returned within ten days. If the applicant refuses the agreement, a contract is



STATE OF MONTANA
APPLICATION FOR EMPLOYMENT

AN EQUAL OPPORTUNITY EMPLOYER

FOR STATE USE ONLY

INSTRUCTIONS: Applications that are not filled out completely cannot be considered. If a question does not apply to you write in letters "NA". Completed applications will not be acknowledged until job opportunities occur. Applications are retained for six months, except those for Merit System positions which are retained for thirty months. To be considered for employment, you must submit a new application. Mailed applications are to be addressed to: State Personnel Division, Capitol Building, Helena, Montana 59601.

PERSONAL DATA		EMPLOYMENT INTERESTS	
1. Name	Last First Middle	11. Type of Work Desired	A B C
2. Address	Street City State Zip	12. Will you accept:	Yes No
3. Phone Number	4. Social Security No.	Permanent Work?	Temporary Work?
5. Date of Birth	6. Present Age	Full-time Work?	Part-time Work?
7. Marital Status	8. Number of Dependents (excluding self)	Employment anywhere in the State?	
9. ☒ Male ☐ Female	10. Height Weight	If "no" state preference	
		13. Date Available	14. Minimum Monthly Salary
		15. Date of separation if considering short-term employment	
		16. Dates and name of State agency by which previously employed	
		Yes No	
17. Are you a citizen of the United States?			
17a. If you are not a citizen, have you filed a Declaration of Intent?			
18. Do you have a valid Montana driver's license?		Operators	
		Chauffeurs	
19. Have you ever been convicted of a felony?			
If "yes". What? Where?			
20. Have you any physical defects, chronic disease or other disability?			
If "yes," explain:			
21. Are any members of your immediate household employees of the State of Montana?			
If "yes," identify by name, relationship and agency:			
22. Do you claim veteran's preference? (If "yes" and applying for a Merit System position, please request and complete supplemental form.)			
23. Give the name, address and phone number of three persons, other than present or prior employers or relatives, who have knowledge of your character, experience and ability.			
A			
B			
C			
24. If you are applying for a Merit System position, please complete this section. Read the announcements relating to the examination and make sure you have complied with all the requirements. You will be notified of the time and place of examination(s).			
• Examination center preferred:		STATE USE ONLY	
POSITIONS APPLIED FOR		A	R
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Figure 6.2 Applicant Ranking Scale

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25. Mark (x) last year successfully completed ▶		6	7	8	9	10	11	12	13	14	15	16	17	18
LEVEL	NAME AND LOCATION (CITY/STATE)	MONTH/YR FROM TO		MAJOR AND MINOR COURSE OF STUDY		QTR/HR EARNED		DEGREE OR CERTIFICATE						
High School Attended														
COLLEGE OR UNIVERSITY														
Business or Vocational														
Other														

EDUCATION

SPECIAL QUALIF.

26. Describe: licenses and registries; skills with machines; publications authored; professional or scientific societies of which you are a member; typing and/or shorthand speed; honors, awards or fellowships; foreign languages understood or spoken; specialized training; civic activities, etc.

TEN YEAR EMPLOYMENT RECORD (List Most Recent First)

27. Begin with your present or last job and list your employments in reverse order for the last 10 years. Including military service. Indicate if positions were full or part time. Use additional sheets if necessary.

• Do you object to an inquiry of your last employer regarding your character and qualifications? (x) ▶ Yes No

Dates

Salaries

Employer's Name and Address

Immediate Supervisor

Start

End

Duties (include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

Employer's Name and Address

Immediate Supervisor

Start

End

Duties (include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

Employer's Name and Address

Immediate Supervisor

Start

End

Duties (include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

Employer's Name and Address

Immediate Supervisor

Start

End

Duties (include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

Employer's Name and Address

Immediate Supervisor

Start

End

Duties (include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

Employer's Name and Address

Immediate Supervisor

Start

End

Duties (include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

I hereby certify that this application is true and complete to the best of my knowledge. I am aware that any falsification or misrepresentation may disqualify me from any employment with the State of Montana.

Applicant's Signature

Date

PROJECT SUNRISE

Home Visitor Interview Guidelines

1. a. What do you see as one of the most difficult problems faced by parents of handicapped children?
b. If you could give one thing to parents of handicapped children through your home visiting, what would you give them?
2. a. We all have prejudices. What are some of your prejudices and how do you deal with them?
b. Why do you want to work with children?
c. Why would you choose to work with parents?
3. You attend a social function, your good friend states, "I hear you are working with the Smiths. Are they finally getting Jimmy under control?" How would you handle the situation?
4. How do parents rate as decision makers?
5. What frustrations might you anticipate in working with handicapped children and their families and how would you deal with those frustrations?
6. a. Briefly describe the role of a paraprofessional home visitor as you see it.
b. What benefits do you see in accepting the position of home visitor if it were offered to you?
7. What considerations do you feel are important for siblings of the handicapped child?
8. Briefly describe your views of working with normal vs. handicapped children.
9. How soon do you see yourself returning to full time employment?

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HOME VISITOR APPLICANT RATING SCALE

	1. Ability to communicate with and respond to the needs of the families	2. Demonstration of acceptance of individuals as valuable regardless of race, religion, sex, age, handicap or social background	3. A high regard for professional ethics especially in areas of confidentiality	4. A perception of people as being dependable, friendly, worthy and capable of handling personal problems	5. Problem solving ability	6. Dependability in situations where he/she must work with limited supervision.	7. Ability to express ideas to others in individual or small group settings.	8. Basic concept of child growth and development	9. Long-term commitment	Total
SHT	a. ____ b. ____	a. ____ b. ____ c. ____				a. ____ b. ____				
	a. ____ b. ____	a. ____ b. ____ c. ____				a. ____ b. ____				
	a. ____ b. ____	a. ____ b. ____ c. ____				a. ____ b. ____				
	a. ____ b. ____	a. ____ b. ____ c. ____				a. ____ b. ____				
	a. ____ b. ____	a. ____ b. ____ c. ____				a. ____ b. ____				
	a. ____ b. ____	a. ____ b. ____ c. ____				a. ____ b. ____				
	a. ____ b. ____	a. ____ b. ____ c. ____				a. ____ b. ____				

Rating Scale

5 - Excellent
4 - Quite Good

3- Good

2- Fair but still lacking

Total possible points - 55

PROJECT SUNRISE
HOME VISITOR AGREEMENT

This is an agreement between _____ and Project Sunrise
to provide home visits to Project Sunrise families for the period of _____
_____.

1. Project Sunrise will identify clients and families, will provide appropriate training and supervision of the home visitor in keeping with the intent of the written model, and will provide the home visitor with materials necessary to carry out the weekly lesson plans.
2. _____ will provide regular home visits to assigned families in keeping with the role and duties outlined in the written model and will complete the required record keeping associated with those visits.
3. _____ will participate in training activities conducted by Project Sunrise.
4. Project Sunrise will pay _____ per home visit and \$5.00 for each home visit which is attempted but which the parents fail to cancel or to show or for telephone conferences approved by the supervisor and in addition will pay mileage to and from home visits at a rate of 17¢/mile.

Both parties agree that this document includes the entire agreement between the parties and that no other conditions are implied or intended.

This agreement may be terminated by either party with two weeks written notice.

Date

Project Sunrise Representative

Date

Signature

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then offered to the second applicant who is again asked to return the signed contact within ten days. Once a trainee has accepted a contract, the coordinator is notified by the specialist that the position has been filled. All other applicants for the position are notified in writing of the filling of the position.

Orientation

The specialist assigned to the home visitor trainee is responsible for meeting with each contracted trainee prior to pre-service training. At this time the specialist notified the trainee of the dates, times and expectations for the pre-service training session. Anticipated expenses and reimbursement procedures should be discussed as well as the agenda for the training session.

Materials will be provided which the home visitor will be expected to read and/or complete prior to the pre-service training experience. The programmed text Understanding the Project Sunrise Model and the Preschool Observation Packet are included in Appendix C.

Developmental materials including the following will also be provided.

- 1) Preschool Profile
- 2) Portage Guide to Early Education Checklist
- 3) Children Children Children (one to five years old)

The programmed text and the preschool observation and experience are to be completed prior to the preservice training workshop. The supervisor is responsible for making arrangements for the preschool observation at a local preschool serving three-, four-, and five-year-olds. During at least one of the three preschool observations, the supervisor accompanies

the trainee and assists in the completion of the assignments for that day.

Additional activities during the orientation period will also help to prepare the trainee for the pre-service training workshop. These are primarily observation activities which permit the trainee to observe the administration of screening (DDST, DEST, DASE) or assessment (CAMS/UPAS) instruments. It is also beneficial if the trainee has the opportunity to observe a home visit conducted by the supervisor. However, if time is limited it may be necessary to wait until the in-service training period to observe these activities.

Pre-Service and In-Service Training

Training of the paraprofessional home visitor will consist of both a pre-service training session and periodically scheduled in-service training sessions. This training program is described in Appendix C.

Prior to beginning their work as a paraprofessional home visitor each trainee will be required to attend a pre-service training workshop at Eastern Montana College conducted by the early childhood special education specialist and center aides. High priority behavioral objectives will be selected from the following competency areas:

1. The Project Sunrise Model
2. Identification and Screening
3. Assessment
4. Planning and Implementation of the FEP
5. Child Program Planning and Implementation
6. Legal Rights

Instructional activities and materials and evaluation techniques have been selected an/or developed to assure competency for each objective selected.

Objectives for in-service training will be based upon needs identified by the home visitor and the specialist. Options for delivery of in-service training experiences include:

1. Individual sessions conducted by the specialist with an individual home visitor.
2. Part-day or full-day sessions conducted by the specialist with all home visitors assigned to that specialist.
3. In-service workshops conducted at a demonstration site with all home visitors present.

At the completion of the pre-service and in-service training, the paraprofessional should demonstrate competency in each of the six competency areas discussed previously.

Service Provision

The initial home visit to a family is always made by the early childhood special education specialist in conjunction with the paraprofessional home visitor. The objectives of this first home visit are:

1. To meet the child and family.
2. To explain the services offered by Project Sunrise and the process which is used to provide services.
3. To observe parent-child interaction patterns for purposes of screening.
4. To informally assess the parents' needs and concerns regarding their child and his or her problems.
5. If the parents are willing, for the home visitor to administer the Denver Developmental Screening Test (DDST) or the Comprehensive Identification Process (CIP).
6. For the early childhood special education specialist to share the results of the DDST with the parents.

Ideally, following this visit the specialist and the home

visitor should have the opportunity for at least a brief staffing regarding their impressions of the home situation, family and child. Another purpose of this staffing might also be for both the specialist and the home visitor to give each other feedback regarding appropriate techniques and approaches to be used during subsequent home visits.

If the parents have been unwilling to give their permission to screen their child, the home visitor may need to make one or more additional home visits before the parents permit administration of the DDST or CIP. In these cases, the home visitor should share the scoring of items with the parents and indicate that the specialist will be contacting the parents regarding the eligibility decision after the results have been examined. The home visitor should not interpret the results nor suggest an eligibility decision regarding the child unless previous arrangements have been made with the assigned specialist.

In cases where a diagnostic evaluation has been completed prior to referral, administering a screening is usually unnecessary. In this case it is advisable for the home visitor and specialist to meet jointly with the family to explain Project Sunrise services. If the parents would like to begin a home program, the parents should sign a Consent for Mutual Exchange of Information Form (Figure 5.2) so that the evaluating agency can release their results to the specialist. This type of referral generally eliminates the need to pursue further in-depth diagnostic evaluation.

The next one, two or three home visits are conducted by the

paraprofessional home visitor alone. The purpose of these visits is to conduct the assessment procedure with the child. The motor, self help, and social- emotional portions of The Curriculum Assessment and Monitoring System, (CAMS) and the preacademic and communication portions of the Uniform Performance Assessment System (UPAS) are administered to the child in the areas where delays have been identified. During these same home visits the home visitor is responsible for observing the home and parent-child interaction patterns so that the Home Observation for Measurement of the Environment (HOME) can be completed. Care should be taken to schedule these assessments during a time when the child is most wakeful and cooperative.

The home visitor is responsible for sharing the results of the child's assessment with the parents emphasizing areas of strength as well as deficits. It may be advisable to chart this graphically on The Preschool Profile.

Following the administration of the child's assessment, and the administration of the HOME, the early childhood special education specialist and the home visitor may make a second joint home visit. The purposes of this visit would be:

1. For the early childhood special education specialist to administer the Alpern-Boll Developmental Profile to the child.
2. For the parents, home visitor and specialist jointly to

develop a temporary IIP for the child which outlines the child's educational objectives prior to a diagnostic evaluation.

3. To provide the parents with the opportunity to designate goals which they have for the Family Education Plan (FEP).

Unless the child lives in a single-parent home, this home visit should preferably be scheduled when both parents can be present, since it is important for both of them to have input into the planning of the program.

Following the home visit, the specialist and the home visitor should meet to write the FEP objectives and to identify appropriate activities to meet both the FEP and the temporary IIP. Some parents will be asked to take baseline data as part of their child's diagnostic evaluation process; therefore, time may need to be spent clarifying for the home visitor, those behaviors on which the parent will be taught to take data. In addition, time may need to be spent discussing appropriate materials to use for other FEP activities and making arrangements to assure that the home visitor can receive necessary lending library materials.

Subsequent home visits will generally be made alone by the home visitor unless the specialist accompanies the home visitor for supervisory purposes. Such supervisory visits should be made frequently with inexperienced home visitors, perhaps as often as once a month. With more experienced home visitors the specialist

may accompany them only once every three to four months.

Another joint conference, between the parents, the specialist, and the home visitor should be held following the diagnostic evaluation. These people plus other professionals responsible for implementing an appropriate educational program become the Child Study Team (CST). The purpose of the CST is to develop the child's Individualized Educational Plan (IEP). The objectives chosen for inclusion should be based upon the recommendations made by the diagnostic evaluation team as well as the functional skills assessment and parent data. These objectives should then be prioritized by the parent according to the needs which they see and value most for their child. By permitting the parents the opportunity to prioritize the objectives it is more likely they will recognize the importance of working systematically with their child to develop skills.

One consideration in choosing the first one or two weekly objectives on either the temporary or permanent IIP should be whether or not the child is capable of obtaining the skill within the week. It is crucial that the first couple of lesson plans be designed in such a way that the parents can see and experience success. If the first skills chosen are too difficult, the child will not be successful, and the parents are likely to become discouraged. For this reason it is important that the home visitor and the specialist work together to design a highly successful lesson activity for the first week or two of the program.

The second consideration regarding the child's program involves implementing prescriptive teaching experiences prior to the diagnostic evaluation. Due to the fact that it is sometimes extremely difficult to obtain a diagnostic evaluation through trained specialists for preschoolers in Montana, it is possible that the evaluation may not be completed for sometime following the functional skill assessment. To prevent the child from falling further behind while waiting, it may be important for the parents to begin diagnostic/prescriptive teaching activities relative to the temporary IIP with the child prior to the diagnostic evaluation. In this case weekly lesson activities should be carefully monitored by the early childhood special education specialist. Caution should be exercised, especially if medical problems are suspected, and activities modified.

Preparation for the Home Visit

Prior to the appointment the home visitor should review the Home Visit Report from the previous week, outline those objectives to be accomplished during the home visit, set up the tentative activities to be used to meet those objectives and make sure that the necessary materials are available. It may be necessary to review assessment procedures to be used and to find and arrange forms which require the parents' signatures. If homemade materials are to be used, it may be necessary to prepare these. In addition, the home visitor should check to assure that any obligations made to the family during the previous home visit have been fulfilled.

If the home visitor goes into the home prepared for the weekly session, he or she will be more self-confident and in a better position to inspire confidence and trust in the family.

It is recommended that each home visitor carry copies of all required forms and a mobile materials kit with them to each appointment. If the planned material appears to be inappropriate, a new material can then be quickly substituted. Also materials from the kit can be used to entertain siblings and help to assure that they do not become jealous and resentful of the attention paid to the handicapped child during the weekly visit. Having copies of forms on hand assures that they will be available if they are unexpectedly needed.

Scheduling and Keeping Appointments

It is crucial that the home visitor understand the importance of 1) keeping scheduled appointments and 2) being on time. The success of the home visitors in large part is dependent upon the parents' perception of them. Their respect for the family is demonstrated in part by their willingness to keep scheduled appointments and to be on time. When emergencies arise that make it impossible for the home visitor to keep the appointment or that cause the visitor to be late, the home visitor should telephone the family to notify them of the change of plans and if possible to reschedule the appointment. The trust relationship which should develop between the home visitor and the family may be seriously impaired if the family finds that he or she is undependable in keeping appointments.

Putting the Family at Ease

Especially in the beginning it will be important for the home visitor to put the family at ease. This can be done in part by prompt arrival for the appointment. If the home visitor approaches the family with self-confidence and friendliness, this will definitely aid in making the family comfortable and at ease. In addition the home visitors should be conscious of their dress. Since in most cases the family will be dressed rather casually in their own home, it is appropriate for the home visitor to dress comfortably and somewhat casually keeping in mind that the family's impression of them will be made in part on the basis of outward appearances. In many cases women may find it more appropriate to wear pants since demonstrations and positioning with children frequently take place on the floor.

Supervision and Evaluation

The paraprofessional home visitor and the training of those holding home visitor positions is the direct responsibility of the early childhood special education specialist. The specialists are responsible for designing appropriate orientation, pre-service and in-service training activities to meet those needs and for assessing the effectiveness of training activities. In addition, the ongoing supervision of the home visitors is the responsibility of the specialist assigned to the geographic region. Periodic visits will be made with both the home visitor and the specialist

present to assess the home visitor's strengths and needs in working with families.

At the completion of the three-day pre-service training workshop the home visitor will be required to complete a self-evaluation on the Competency Area Rating Scale for Paraprofessional Home Visitors (Figure 6.8 to 6.13). Periodically thereafter the home visitor will again be asked to re-evaluate themselves on those objectives stressed during the training session.

Every two months following pre-service training, the supervisor and the home visitor should have a needs assessment conference to identify and prioritize needs for future in-service training sessions. In addition it is advisable for the specialist to informally discuss needs for staff development during each supervisory session and spend at least one-half hour during each session meeting the home visitor's training needs. In addition, at the close of small or large group workshops, each trainee will be asked to evaluate the quality of training received and their satisfaction with the training. That evaluation might take the form of a conference with the assigned supervisor and/or a written workshop evaluation.

Other training evaluation techniques which may be employed include the use of videotaped role playing and/or home visits and analysis of those tapes to determine whether the home visitor is applying the skills learned during training.

I have expert knowledge and/or skill to implement with proficiency.

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information.

I need more knowledge and skill before I could implement with assistance.

I have little knowledge or skill.

I have no knowledge or skill.

Competency #1 - The Project Sunrise Model

The paraprofessional home visitor will be able to explain the Project Sunrise service delivery model as well as the roles of staff and parents.

The paraprofessional home visitor will be able to:

1. Describe the purpose of Project Sunrise and other Handicapped Children's Early Education Programs (HCEEP or First Chance Network).
2. Explain why a home-based parent training program is a viable delivery option.
3. Describe which children are eligible to receive services through Project Sunrise.
4. Describe the procedure for making a referral.
5. Describe the role of screening, assessment, The Family Education Program (FEP), evaluation, The Individualized Educational Plan (IEP) the Individualized Instructional Plan and re-evaluation.
6. Describe the responsibilities and competencies needed by the parent in teaching their child.
7. Describe the role and responsibilities of the paraprofessional home visitor.
8. Describe the role and responsibilities of the center aide.
- Describe the role and responsibilities of the early childhood special education specialist.

1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

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Competency #2 - Identification and Screening

The paraprofessional home visitor will be able to assist in finding preschool children with exceptional needs and implementing screening procedures to help determine whether those children are eligible for Project Sunrise services.

The paraprofessional home visitor will be able to:

1. Describe normal developmental milestones for children birth through six in the areas of preacademic skills, language skills, motor skills, self-help and social-emotional skills.
2. Describe the purpose and importance of early and periodic screening.
3. Administer and score screening procedures using the Denver Developmental Screening Test.
4. Administer and score screening procedures using the Denver Articulation Screening Examination.
5. Administer and score screening procedures using the Denver Eye Screening Test.
6. Observe home conditions, parent behaviors and parent/child interaction patterns that might indicate conditions of risk to the child.

I have no knowledge or skill.

I have little knowledge or skill.

I need more knowledge and skill before I could implement with assistance.

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information.

I have expert knowledge and/or skill to implement with proficiency.

1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

I have expert knowledge and/or skill to implement with proficiency.

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information.

I need more knowledge and skill before I could implement with assistance.

I have little knowledge or skill.

I have no knowledge or skill.

Competency #3 - Assessment

The paraprofessional home visitor will be able to administer, score and interpret the results of the assessment instrument(s).

The paraprofessional home visitor will be able to:

1. Describe the relationship between screening, assessment, evaluation and instruction.
2. Administer and score the Curriculum Assessment and Monitoring System (CAMS) and preacademic portion of the Uniform Performance Assessment System (UPAS).
3. Explain the results of the CAMS/UPAS assessment to the parents.
4. Describe the relationship between knowledge of normal child growth and development and educational assessment.

1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #4 - Planning and Implementing the Family Education Program (FEP).

The paraprofessional home visitor will be able to aid in planning and to implement the Family Education Program Plan.

The paraprofessional home visitor will be able to:

	I have no knowledge or skill.	I have little knowledge or skill.	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information.	I have expert knowledge and/or skill to implement with proficiency.
1. Identify the nine major categories of handicapping conditions recognized by Montana Special Education Rules and Regulations.	1	2	3	4	5
2. Define the needs of the family (e.g. financial, educational, nutritional, social and emotional areas).	1	2	3	4	5
3. Define the needs which the family has for the handicapped child, e.g. medical, financial, respite card, educational needs).	1	2	3	4	5
4. Describe the effects of handicapped children upon the parents, siblings and extended family.	1	2	3	4	5
5. Describe the effects of the parents, siblings, and extended family upon the handicapped child.	1	2	3	4	5
6. Provide feedback to parents regarding cues, and consequences in parent/child interaction sequences.	1	2	3	4	5
7. Record child performance data on CAMS data sheets.	1	2	3	4	5
8. Identify inexpensive teaching materials available within the home.	1	2	3	4	5

Competency #4 - Planning and Implementing the Family Education Program (FEP) Continued

	I have no knowledge or skill.	I have little knowledge or skill.	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information.	I have expert knowledge and/or skill to implement with proficiency.
9. Identify informal teaching opportunities which parents can use with their child.	1	2	3	4	5
10. Demonstrate modeling and expansion techniques which parents can use to stimulate language development.	1	2	3	4	5
11. Demonstrate skill in the use of active listening techniques.	1	2	3	4	5
12. Describe a child-centered learning environment within the home.	1	2	3	4	5

Figure 6.11 Competency #4 Continued

I have expert knowledge and/or skill to implement with proficiency.

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information.

I need more knowledge and skill before I could implement with assistance.

I have little knowledge or skill.

I have no knowledge or skill.

Competency #5 - Child Program Planning and Implementation

The paraprofessional home visitor will be able to develop, demonstrate and evaluate weekly lesson activities for the parents to do with the child.

The paraprofessional home visitor will be able to:

1. Identify a weekly lesson plan activity to meet a short term goal on the child's IIP.
2. Demonstrate and explain the weekly lesson activity for the parents.
3. Adapt weekly lesson activities to meet the needs of the handicapped child by using task analysis.
4. Develop, identify, and/or secure materials needed to implement the weekly lesson activity.
5. Identify optimum times, locations and positioning that comprise the best educational setting for implementing the weekly lesson activity.
6. Provide appropriate feedback to parents regarding the cues and consequences used in implementing the weekly lesson activity.
7. Modify instructions and data recording procedures to meet the skill level of the parents.
8. Complete the Home Visit Report Form.

1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #6 - Legal Rights

The paraprofessional home visitor will be able to experience the rights guaranteed to young handicapped children and will demonstrate respect for those rights.

The paraprofessional home visitor will be able to:

1. Explain the basic rights guaranteed a preschool handicapped child and the family through PL 94-142 and Montana House Bill 816.
2. Implement procedures related to confidentiality of records.
3. Explain due process procedures to parents.

I have expert knowledge and/or skill to implement with proficiency.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information.	I need more knowledge and skill before I could implement with assistance.	I have little knowledge or skill.	I have no knowledge or skill.	
5	4	3	2	1	1. Explain the basic rights guaranteed a preschool handicapped child and the family through PL 94-142 and Montana House Bill 816.
5	4	3	2	1	2. Implement procedures related to confidentiality of records.
5	4	3	2	1	3. Explain due process procedures to parents.

Additional data regarding the performance of the home visitor will be taken during supervisory visits from the assigned early childhood special education specialist. In addition to observational data taken during supervisory sessions, the child/family records kept by the home visitor should be examined for completeness and accuracy.

In some cases it may not be possible for the supervisor to accompany the home visitor as frequently as would be desirable. In this case the home visitor should ask permission of the family to tape record the home visit. The tape can then be mailed to the supervisor and feedback regarding the home visitor's performance relayed by telephone. This is considered merely a supplementary method of supervision; however, weather and distance may make it a valuable supervisory tool.

Additional data will be kept on each communication to or from the center staff. Periodic telephone conferences between the center staff and the home visitor may be recorded on the Home Visit Report Form (Figure 6.1) and checked and monitored weekly by the specialist. The purpose of these conferences is to communicate the data collected by the family and the home visitor to the center staff so that appropriate weekly lesson activities can be planned for the next home visit. The home visitor and center aide or specialist can then decide together whether new activities should be introduced during the subsequent visit by the home visitor.

At least every two or three weeks a scheduled phone conference is held between the home visitor and the specialist to provide feedback to one another regarding the child and family services provided. Additional phone conferences (or if necessary, supervisory visits) should be scheduled when problems arise or when the home visitor is in need of someone with whom to share their job-related anxiety or frustration. It is the responsibility of the assigned supervisor to serve as a support system meeting the needs of the paraprofessional home visitor while at the same time assuring that the confidentiality of the family is protected. Having a supervisor who is available to listen and share ideas should provide a constructive opportunity to solve problems which naturally arise in dealing with families.

Annually parents will be asked to complete the Parent Satisfaction Evaluation Form (Figure 6.14) to evaluate their satisfaction with services provided through Project Sunrise. Periodic phone or personal contacts will provide additional evaluative information. Attention will be focused particularly upon the services provided by the home visitor. During the first home visit each parent will be given the name, address and telephone number of the early childhood special education specialist and the coordinator. At any time the parents should feel free to

PROJECT SUNRISE

Parent Satisfaction Evaluation Form

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1. The home visitor provided appropriate materials to aid me in working with my child.	5	4	3	2	1
2. The home visitor demonstrated the activities to be used with my child.	5	4	3	2	1
3. The home visitor clearly answered any questions I had pertaining to the use of the materials.	5	4	3	2	1
4. My child enjoyed working with the home visitor.	5	4	3	2	1
5. Home visits should be scheduled once a week.	5	4	3	2	1
6. The home visitor provided me with information about my child's particular handicap.	5	4	3	2	1
7. I would feel comfortable about contacting Project Sunrise between home visits.	5	4	3	2	1
8. Training I received at the Sunrise Center aided me in working with my child (do not answer if you did not receive training at Sunrise Center).	5	4	3	2	1
9. Training I received at home aided me in working with my child.	5	4	3	2	1
10. I feel training should be scheduled <u>only</u> in my home.	5	4	3	2	1
11. I feel training should be scheduled at Sunrise Center <u>and</u> in my home.	5	4	3	2	1
12. I feel training should be scheduled <u>only</u> at Sunrise Center.	5	4	3	2	1
13. I would like to meet with other parents of handicapped children.	5	4	3	2	1
14. I am satisfied with services received through Project Sunrise.	5	4	3	2	1

COMMENTS:

contact either the assigned specialist or the coordinator regarding concerns about the services the family is receiving.

The following will be considered grounds for dismissal of the paraprofessional home visitor.

1. Disrespect for parents' rights to confidentiality.
2. Inability to implement service delivery procedures (e.g. missing family appointments).
3. Failure to maintain records or to communicate with the center staff.
4. Constant and long-term parent dissatisfaction.
5. Misconduct that impairs the trust relationship with the family.

The following procedures will be used to dismiss a paraprofessional home visitor so that every possible effort can be made to bring the home visitor's performance up to standards:

1. The assigned supervisor notifies the home visitor of the problem through one verbal warning and documenting that warning in the home visitor's records.
2. The assigned specialist gives a written warning which refers to the verbal warning and notifies the home visitor that if expectations are not met by a specific deadline, the home visitor will have cause to be terminated.
3. The coordinator notifies the home visitor of termination

in writing referring to both the verbal and written warnings.

Paid Paraprofessionals vs. Volunteers

It is believed that hiring paraprofessionals as staff members has several advantages over engaging volunteer help. The most important reason is that the program developers then have control over all aspects of the project. The home visitor can be required to comply with all procedures necessary to fully implement the model. It is also felt that home visitors will be more highly motivated to keep scheduled appointments, especially since weather and road conditions in Montana are frequently less than optimal.

Another factor not to be disregarded is that home visitors need reinforcement for doing their job well. Although money is not the only reinforcer which should be available to the home visitor (others include training, social contacts and personal job satisfaction), it certainly helps to lend dignity to the position and to elevate its importance.

By "contracting" with the trainee on The Home Visitor Agreement, it is hoped that turn-over can be minimized. Trainees are requested to make a minimum of a twelve-month commitment to the project so that there is continuity in the family services which Project Sunrise can provide.

Paraprofessional home visitors will be paid on an hourly basis and will be reimbursed for travel mileage according to state travel allowance. Most home visits take approximately one to one-and-one half hours and an additional half hour is generally

Month _____

170

Families Receiving Direct Services

Figure 6.15 Monthly Service Delivery Expenditures

required to complete the necessary paperwork and communication. The home visitor will be paid for two hours per home visit regardless of the exact amount of time spent in the home. By offering wages slightly higher than local teacher's aides receive, Project Sunrise hopes to attract paraprofessional trainees who are actually professionals in other areas but who are presently desiring part-time work. In addition the pay scale should help compensate for travel time without actually requiring the record-keeping and supervision that direct payment for travel time would necessitate.

Board, room and travel will be provided for paraprofessional trainees to attend the pre-service training workshop. In addition a small stipend will be awarded to help compensate for training time.

In order to facilitate accounting procedures, each home visitor submits a Home Visitor Record of Monthly Service Delivery Expenditures (Figure 6.15) on the last day of the month. This summarizes services provided and expenses incurred and permits additional monitoring of service provisions to families.

SUMMARY

The effectiveness of the paraprofessional home visitor is determined in large part by the training and supervision which they receive. For this reason competencies in six areas have been specified. Recruitment and selection procedures have been designed to help assure that competent trainees are identified.

Orientation, pre-service and in-service training procedures have been designed to assure that the competencies specified are obtained. The procedures for conducting the home visit and the relationship

between the early childhood special education specialist, the home visitor and the center staff have been outlined. Supervision and evaluation procedures have also been developed. This planning should help to assure that those paraprofessionals hired to implement the Project Sunrise model are effective as home visitors in working with the families of preschool handicapped children.

Chapter 7

THE CENTER STAFF

The center staff is comprised of staff members at three levels in addition to the secretary. The center aides are responsible for maintaining the lending library and for keeping and compiling program-related data. If their qualifications are such that they can provide technical assistance to the paraprofessional home visitors, they may have home visitor training responsibilities. They may also be assigned responsibility for data collation and statistical analyses. The early childhood special education specialist is responsible for the training and supervision of the paraprofessional home visitors and for assuring appropriate programming for the handicapped child and the family. The coordinator is responsible for the administrative aspects of the program. Together the center staff assures that an appropriate program is delivered to both children and families.

Center Aide

If possible, the center aides should be trained and qualified, early childhood, elementary or special education teachers since this position may require lesson plan development in accordance with the child's IEP.

Preferably the center aides should have experience or training in working with preschool children. If the center aide does not have teacher training or comparable background in another

field, such as behavioral psychology, the responsibility will be limited to those duties which are primarily clerical. If the center aides have skills in teaching adults, they will also be responsible for aiding the early childhood special education specialists in planning and implementing the paraprofessional home visitor training sessions.

If the center aides are appropriately trained and are assigned technical assistance responsibilities, they will need skill in communicating by telephone. In this role they will be conferring weekly with the paraprofessional home visitors by phone. Because they will often be helping the home visitors solve problems related to the child's or family's program, they should also be skilled at facilitating problem-solving and should have the ability to task analyze a skill.

The following are clerical responsibilities assigned to every center aide:

1. To maintain a filing system of child and family records.
2. To aid in administering screening procedures.
3. To make arrangements with the appropriate agencies to schedule the child's interdisciplinary diagnostic evaluation.
4. To develop and implement procedures for maintaining an effective lending library.

5. To assure that paraprofessional home visitors receive the necessary materials for child and family program implementation.
6. To collect, collate and prepare program evaluation data for staff and/or public distribution.

Depending upon the training and qualifications of the center aide, the following technical assistance responsibilities may also be assigned:

1. To make occasional telephone calls to the paraprofessional home visitors for the purpose of collecting child performance data.
2. To assist home visitors in developing appropriate weekly lesson activities for the child and/or the family during the weekly phone conference.
3. To aid the early childhood special education specialists in planning, conducting and evaluating paraprofessional training sessions.

In addition to those competencies needed by paraprofessional home visitors, competencies in the following six additional areas have been identified for the center aides:

1. Identification and Screening
2. Program Planning and Implementation
3. Evaluation and Program Placement
4. Lending Library

5. Paraprofessional Home Visitor Training

6. Data Collection

(Figures 7.1 through 7.6)

Each center aide will be asked to evaluate themselves quarterly in each of these five competency areas. (If the center aide's duties are limited to clerical responsibilities, self-evaluation in competency areas 2 and 3 will be unnecessary). Staff development plans can then be designed to strengthen areas of deficit. In addition center aide performance will be formally evaluated by the early childhood special education specialist semi-annually.

The technical assistance role of the center aide should be viewed as one of ~~liaison~~ and trouble shooter. Center aides with technical assistance responsibilities are required to initiate weekly telephone communication with the paraprofessional home visitors. In turn they are required to transmit problems and progress data to the early childhood special education specialists who are ultimately responsible for the success of the child's program. For this reason they must have excellent communication skills. The center aides may be able to help the home visitors solve many of the minor problems which they encounter if they are skilled in task analysis. In addition their ability to facilitate problem-solving during telephone conferences may alleviate much of the "fire-fighting" burden which would otherwise fall to the specialist. Major problems can and should be the responsibility of the

Competency #1 - Identification and Screening

The center aide will be able to assist in the implementation and evaluation fo screening procedures to determine whether the child is eligible for Project Sunrise services:

In addition to those competencies needed by parprofessional home visitors, the center aide will be able to:

1. To assist in planning and implementing public awareness and child find procedures.
2. Assist in the planning and implementing of mass screening procedures.
3. Observe, record and interpret the results of the parents.
4. Develop and implement a filing system to record screening results.

I have no knowledge or skill

1

1

1

1

I have little knowledge or skill

2

2

2

2

I need more knowledge and skill before I could implement with assistance.

3

3

3

3

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information

4

4

4

4

I have expert knowledge and/or skill to implement with proficiency

5

5

5

5

Competency #2 - Program Planning and Implementation

The center aide will be able to assist the early childhood special education specialist and the home visitors in the planning, implementation, and evaluation of the child's Individualized Instructional Plan (IIP) and the Family Education Program (FEP).

In addition to those competencies needed by the paraprofessional home visitor, the center aide will be able to:

1. Task analyze the child's IEP in order to develop weekly lesson activities that can be demonstrated by the paraprofessional home visitor and implemented by the parents.
2. Communicate and record suggestions for weekly lesson activities to paraprofessional home visitors during weekly telephone conferences.
3. Evaluate weekly lesson activities identified by home visitors.
4. Collect, record and file child performance data obtained by the home visitors and early childhood special education specialists.
5. Recommend appropriate materials which the paraprofessional might use in helping the family reach the FEP objectives.
6. Facilitate problem solving with the paraprofessional home visitor who encounters difficulties with the child and family program

I have no knowledge or skill	I have little knowledge or skill	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Figure 7.2 Competency #2 (Center Aide)

Competency #3 - Evaluation and Program Placement

The center aide will be able to schedule and make the necessary arrangements for the child's diagnostic evaluation under the direction and supervision of the early childhood special education specialist.

The center aide will be able to:

1. Write the necessary letters or make the required telephone calls to arrange for the child's diagnostic evaluation.
2. Communicate with professionals in various agencies with whom diagnostic evaluations are scheduled.
3. Request and obtain written statements of eligibility, as well as dissenting opinions, from evaluation personnel to assist in appropriate program planning.
4. Maintain evaluation records and the child's file in such a way as to protect family confidentiality.

I have no knowledge or skill

I have little knowledge or skill

I need more knowledge and skill before I could implement with assistance.

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information

I have expert knowledge and/or skill to implement with proficiency

1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #4 - Lending Library

The center aide will be able to plan and implement a procedure for assuring that parents and paraprofessional home visitors have access to the materials in the lending library.

The center aide will be able to:

1. Develop an appropriate check-out system to record loans from the lending library.
2. Make plans to assure delivery of materials from the lending library to the paraprofessional home visitors and/or parents
3. Assure that materials loaned are clean, complete and in good repair

I have no knowledge or skill	I have little knowledge or skill	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #5 - Paraprofessional Home Visitor Training

The center aide will be able to help plan, implement and evaluate procedures for training paraprofessiona home visitors.

The center aide will be able to help the early childhood special education specialists:

1. The center aide will be able to help the early childhood special education specialist prioritize objectives for paraprofessional training sessions.
2. Plan and develop appropriate training activities to be used during the paraprofessional training session.
3. Select and prepare appropriate materials for use during the training activities.
4. Use audiovisual equipment including the videotape records and player, filmstrip and movie projectors and cassette player/recorder equipment.
5. Lead training sessions, facilitate group discussions, participate in role playing situations and execute all training activities.

I have no knowledge or skill

I have little knowledge or skill

I need more knowledge and skill before I could implement with assistance.

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information

I have expert knowledge and/or skill to implement with proficiency

1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Figure 7.5 Competency #5 (Center Aide)

Competency #6 - Data Collection

The center aide will be able to implement data collection procedures developed in conjunction with the early childhood special education specialist and collate and prepare that data for staff and/or public distribution.

The center aide will be able to:

1. Initiate and record weekly telephone conferences with each paraprofessional home visitor.
2. Communicate problems and necessary information to the early childhood special education specialist when such problems are encountered by the home visitor.
3. Collect raw data from parents, early childhood special education specialists, paraprofessional home visitors and parents at the request of the early childhood special education specialist coordinator.
4. Demonstrate skill in mathematics, data analysis elementary statistics, and graph and chart representations.

I have no knowledge or skill	I have little knowledge or skill	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

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Figure 7.6 Competency #6 (Center Aide)

9
specialist. However, if the center aide can troubleshoot the less significant problems which arise, this will free the special education professional to deal with the harder-to-solve problems.

Early Childhood Special Education Specialists

The early childhood special education specialists serve as the trained, professional special education teachers required in Montana Special Education Rules and Regulations (48-2.18 (34)-S18520). This regulation requires that "a special education teacher must be certified with an endorsement in special education. Special education endorsement is granted upon completion of a program approved by an accredited college or university". In addition to their special education certification, the specialist should also have training and experience in early childhood education. The following qualifications are needed for the position:

1. B.S. or B.A. degree in Special Education, and/or M.S. degree in special education or an equivalent degree in a related field.
2. Specific training and coursework in preschool education for the handicapped.
3. Teaching experience with preschool handicapped children, ages birth to six.
4. Experience in working with and training the parents of preschool handicapped children.

5. Knowledge of and experience with "packaged" training materials for teaching preschool handicapped children and their parents.
6. Availability to work on a full-time basis with acceptance of responsibility for traveling to various training delivery sites throughout the assigned geographic region.
7. Ability to administer and score various screening and educational assessment instruments appropriate for a preschool handicapped population.

The following general responsibilities comprise the role of the early childhood special education specialist:

1. To identify, screen, assess, plan appropriate interdisciplinary diagnostic evaluations, and plan, implement and evaluate intervention programs for handicapped children ages birth through six years.
2. To assess family needs for identified handicapped preschool children and plan, implement and assess appropriate Family Education Programs to meet the educational needs of the families served.
3. To recruit, interview, select, train and supervise paraprofessional home visitors within the assigned geographic region.
4. To communicate with and coordinate activities between the paraprofessional home visitors, the center aides,

the early childhood special education specialists and the administrative staff.

5. To facilitate referral of children and/or families to appropriate agencies within the total human services system and develop a cooperative working relationship with those agencies.
6. To advocate for exemplary preschool services for handicapped children throughout the state by staying abreast of current educational and legislative trends and by working with current and planned programs to implement exemplary practices.
7. To strive to implement the model systematically and to be a resource to schools and agencies desiring to replicate the model.
8. To participate in group decision-making regarding the project and to implement group and administrative policies and decisions.
9. To participate in the program monitoring, evaluation, data collection and report writing related to the model and the program.
10. To strive to protect the rights of handicapped preschool children and their parents and to respect the parents' right to make decisions regarding their child's education and welfare.

The early childhood special education specialists should have all of those competencies needed by the parents, the paraprofessional home visitor and the center aides. There are, in addition, ten more competency areas which are needed to fulfill this position.

They are as follows:

1. Identification and screening
2. Assessment
3. Family Education Program
4. Diagnostic Evaluation
5. Program Placement
6. Program Planning
7. Program Evaluation
8. Paraprofessional Home Visitors
9. Interagency cooperation
10. Model Implementation

(Figures 7.7 to 7.16)

Responsibilities of the Early Childhood Special Education Specialist
To Children and Families

Ultimately the early childhood special education specialists are responsible for assuring that appropriate programs are planned and implemented for handicapped children. In addition they are responsible for assuring that the Family Education Programs meets the needs of other family members. In order to assure that the needs of the children and the families are met, the specialist

Competency #1 - Identification and Screening

Early Childhood Special Education Specialists will be able to plan, implement and evaluate identification and screening procedures to assure that handicapped preschool children receive the needed services.

In addition to those competencies needed by the paraprofessional home visitor and the center aide, the Early Childhood Special Education specialist will be able to:

1. Plan, implement and evaluate child find procedures.
2. Select reliable and valid educational screening instruments to use with groups of children as well as with individual children.
3. Plan, implement and evaluate a thorough mass screening procedure.
- 187 4. Discuss the importance of, describe the procedures of, and interpret the results of the screening program to the parents.
5. Prepare written and oral reports on the results of screening for appropriate school and nonschool professionals.

I have no knowledge or skill

I have little knowledge or skill

I need more knowledge and skill before I could implement with assistance.

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information

I have expert knowledge and/or skill to implement with proficiency

1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #2 -- Assessment

Early Childhood Special Education Specialists will be able to plan, implement and evaluate appropriate assessment procedures to use with handicapped preschool children and their parents.

In addition to those competencies needed by the paraprofessional home visitor and the center aide the Early Childhood Special Education Specialist will be able to :

1. Select appropriate assessment instruments to allow for the implementation of the child's curriculum, if a curriculum other than the CAMS is to be used.
2. Administer and score assessment instruments other than the CAMS/UPAS when additional instruments are required.
3. Interpret the results of the child's CAMS/UPAS assessment.
4. Interpret the results of the parent behavior instrument.
5. Interpret the results of the parent/child interaction pattern assessment.
6. Plan an appropriate Family Education Program as a result of the assessment procedures.
7. Involve the parents and paraprofessional home visitor in planning the objectives for the Family Education Program.

I have no knowledge or skill

I have little knowledge or skill

I need more knowledge and skill before I could implement with assistance.

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information

I have expert knowledge and/or skill to implement with proficiency

1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #3 - Family Education Program

Early Childhood Special Education Specialists will be able to plan, implement and evaluate the objectives and activities of the Family Education Program (FEP)

In addition to those competencies needed by the paraprofessional home visitor and the center aide, the early Childhood Special Education Specialist will be able to:

1. Involve the parents and the paraprofessional home visitor in planning and prioritizing the objectives for the FEP.
2. Write appropriate objectives for the FEP as a result of the assessment procedures.
3. Involve the paraprofessional home visitor in planning activities to meet those objectives.
4. Supervise and monitor the paraprofessional home visitor's implementation of the activities related to the FEP.
5. Evaluate the effectiveness of the FEP.

I have no knowledge or skill

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1

I have little knowledge or skill

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I need more knowledge and skill before I could implement with assistance.

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3

3

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information

4

4

4

4

4

I have expert knowledge and/or skill to implement with proficiency

5

5

5

5

5

Competency #4 - Diagnostic Evaluation

Early Childhood Special Education Specialist will be able to arrange for appropriate professional specialists to provide a diagnostic evaluation for the child.

Early Childhood Special Education Specialists will be able to:

1. Identify those team members, preferably local professionals, who would be able to evaluate the child.
2. Provide oral and/or written screening results to those professionals with the permission of the parents.
3. Interpret evaluation results for parents and paraprofessional home visitors upon request.
4. Complete antecedent, behavior consequence (ABC) behavior forms when such an observation is appropriate to the evaluation procedure.
5. Take frequency and duration data on child behaviors when such data is appropriate to the evaluation.
6. Administer evaluation instruments in which the specialist is trained and competent.

I have no knowledge or skill	I have little knowledge or skill	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #5 - Program Placement

Early Childhood Special Education Specialists will be able to plan, participate and evaluate the program placement process.

The Early Childhood Special Education Specialist will be able to:

1. Arrange and chair a Child Study Team (CST) meeting between evaluation specialists, parents, and paraprofessional home visitors.
2. Present orally the written evaluation results of those evaluation specialists, unable to attend the CST meeting.
3. Present evaluation data collected by the early childhood special education specialist during the Family Education Program phase.
4. Aid the parents and/or paraprofessional home visitors in presenting data which they have collected, as well as to encourage them to verbalize questions which they might have.
5. Aid the team in making an eligibility decision.
6. To obtain signatures on consenting placement decisions and to obtain written statements from dissenting members of the CST

I have no knowledge or skill	I have little knowledge or skill	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #6 - Program Planning

Early Childhood Special Education Specialists will be able to plan an appropriate Individualized Education Plan (IEP) for a handicapped preschool child.

In addition to those competencies needed by the center aides and the paraprofessional home visitors, the early childhood Special Education Specialist will be able to:

1. Write an appropriate IEP for the child.
2. Aid the parents in prioritizing the educational objectives for the child.
3. Develop or supervise the development of an appropriate quarterly Individualized Instructional Plan (IIP)
4. Supervise the planning of the weekly lesson activities.

I have no knowledge or skill	I have little knowledge or skill	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Figure 7.12 Competency #6 (ECSES)

Competency #7 - Program Evaluation

Early Childhood Special Education Specialist will be able to plan and implement evaluation procedures to determine impact of all project activities.

The Early Childhood Special Education Specialist will be able to:

1. Evaluate the effectiveness of child find procedures.
2. Evaluate the appropriateness of screening procedures.
3. Evaluate the appropriateness of assessment procedures.
4. Evaluate the effectiveness of the FEP.
5. Evaluate the appropriateness of parental cues and consequences
6. Evaluate the appropriateness of the diagnostic evaluation.
7. Evaluate the appropriateness of the placement decision procedure.
8. Evaluate the effectiveness of the IEP, IIP and weekly lesson activities.
9. Evaluate the effectiveness of interagency relationships.
10. Evaluate the effectiveness of pre-service and in-service paraprofessional training.
11. Evaluate the performance of paraprofessional home visitors and center aides.
12. Evaluate self and peer performance.
13. Evaluate parent satisfaction with project services.

I have no knowledge or skill

I have little knowledge or skill

I need more knowledge and skill before I could implement with assistance.

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information

I have expert knowledge and/or skill to implement with proficiency

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1	2	3	4	5
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1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #8 - Paraprofessional Home Visitors

Early Childhood Special Education Specialists will be able to assist in the recruitment, selection, orientation, training and supervision of paraprofessional home visitors.

The Early Childhood Special Education Specialist will be able to:

1. Identify potential paraprofessional home visitors in those communities for which the early childhood special education specialist is responsible.
2. Describe the model, role and responsibilities of paraprofessional home visitors to interested applicants and trainees.
3. Plan, implement and evaluate procedures for the recruitment and selection of trainees for the paraprofessional home visitor positions.
4. Plan, implement, and evaluate appropriate pre-service training activities for use with the selected trainees.
5. Plan, implement and evaluate appropriate in-service training activities for use with the paraprofessional home visitors.
6. Provide oral and written feedback to paraprofessional home visitors on their performance.

I have no knowledge or skill	I have little knowledge or skill	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #9 - Interagency Cooperation

Early Childhood Special Education Specialist will be able to locate and secure the cooperation of other agencies, groups and individuals in the provision of appropriate educational services for young handicapped children and their families and care givers.

The Early Childhood Special Education Specialist will be able to:

1. Identify resources for service delivery within each separate community.
2. Explain the purpose of the project and its scope and limitations to agency representatives.
3. Explain the model to community leaders who are responsible for assuring service provisions to young children.
4. Explain exemplary practices to be implemented in service delivery to young children.
5. Demonstrate a knowledge of and respect for professional practices of allied professionals.
6. Assist in the development, implementation and evaluation of an appropriate educational plan between two or more institutions.
7. Assist in the development, implementation and evaluation of a procedure designed to facilitate the transition between or within these programs and/or services.

I have no knowledge or skill	I have little knowledge or skill.	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Competency #10 - Model Implementation and Human Services

The Early Childhood Special Education Specialist will be able to contribute to positive management of the model implementation and will be able to participate actively in the larger framework of human services systems.

The Early Childhood Special Education Specialist will be able to:

1. Actively involve the individuals affected by the outcomes of a decision in the decision making process (such as chairing a Child Study Team Meeting.
2. Administer reasonable limits on actions of home visitors and center aides without losing flexibility and adaptability to changing circumstances.
3. Supervise and manage the work of the center aides, paraprofessional home visitors and parents patiently, firmly and reasonably.
4. Demonstrate supportive behavior in emergency situations.
5. Modify activities during ongoing activities contingent upon client's responses.
6. Demonstrate skill at implementing various supervisory styles while working with paraprofessionals and center aides.
7. Describe the organization of administrative, supervisory, and instructional systems within the model.
8. Participate actively in group decision making activities related to the model development and program growth.
9. Follow through on policies or procedures related to the model as well as policies or procedures related to administrative decisions.

I have no knowledge or skill

1

1

1

1

1

1

1

1

1

I have little knowledge or skill

2

2

2

2

2

2

2

2

2

I need more knowledge and skill before I could implement with assistance.

3

3

3

3

3

3

3

3

3

I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information

4

4

4

4

4

4

4

4

4

I have expert knowledge and/or skill to implement with proficiency

5

5

5

5

5

5

5

5

5

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Figure 7.16 Competency #1 (ECSES)

Competency #10 - Continued

10. Follow current research and events (legislation, government policies community actions, natural disasters) and will be able to identify implications for program services.

11. Speak publicly about the model or exemplary early childhood education for handicapped preschool children.

I have no knowledge or skill	I have little knowledge or skill	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5

must assure that the model is implemented fully at all levels and that clear, open communication takes place between parents, home visitors, center aides and the specialists.

The responsibilities for child and family programming include the following:

A. Identification (Child Find)

1. To assure media coverage of the project throughout the service area.
2. To assure distribution of project brochures, referral forms and information about the program and thereby inform parents and other professionals about normal versus abnormal child development patterns.

B. Screening

1. To arrange for screening of children using the DDST, the CIP, and/or for compiling recommendations from those professionals who believe that the child is at risk and in need of intervention.
2. To accompany the paraprofessional home visitor on the first home visit.
 - a. To describe program services and limitations to the parents.
 - b. To observe the administration of the DDST by the paraprofessional home visitor.
 - c. To interpret the screening results for the parents and to notify them of program eligibility.

- d. To discuss with the parents the need for the assessment/evaluation process.
3. To staff with the home visitor following the home visit regarding areas of deficit to be assessed during the informal skills assessment of the child.

C. Assessment

1. To assure that the home visitor's administration of the assessment process is complete and accurate and that written parental permission has been previously granted.
2. If substitute or supplementary child assessment instruments are to be used to obtain permission to administer these instruments from the coordinator and to administer the instruments to the child.
3. To review the completed assessment instruments with the home visitor prior to the second joint home visit.
4. Following the home visitor's completion of the assessment process, to make a second joint home visit with the home visitor. The purpose of this home visit is to administer The Alpern-Boll Developmental Profile to the child and to develop the temporary IIP. The specialist is responsible for facilitating parental input into:
 - a. The child's objectives recorded on the temporary IIP
 - b. The parent's educational objectives for themselves which will become a part of the FEP.

D. Family Education Program (FEP)

1. To develop the objectives for the FEP with the home visitor.

Following the second joint home visit, the specialist and home visitor meet and jointly formulate the FEP objectives. High priority will be given to those objectives identified by the parents for themselves.

2. To write up the FEP with specific objectives and to provide a copy of the FEP to the paraprofessional home visitor.

Objectives identified by the family are circled to identify their high priority.

3. To make recommendations to the home visitor for appropriate materials to use in meeting the FEP objectives.

E. Child Diagnostic Evaluation

1. To be responsible for discussing an appropriate interdisciplinary diagnostic evaluation with the family either at the time of the screening or after the parents make a decision to receive services from Project Sunrise. The family's preference regarding where they would like for the evaluation to be done and whom they would like to have do it should be obtained.

2. To assure that the necessary steps are taken to arrange the desired evaluation.

3. To assure that an evaluation team meeting is held following the interdisciplinary evaluation. Whenever possible

all professionals participating in the diagnostic evaluation should be present. It is also advisable to have a public health nurse available to interpret the child's medical records. Representatives of social services, mental health, the day care, Head Start, school or other agencies directly involved with the child and/or family should be encouraged to participate if they so desire.

In some cases it may be necessary to proceed with merely the written recommendations of the evaluation team. This would definitely be a less than optimal situation. However, distance, cost, time and the low priority presently given to preschool evaluations in Montana may make it a necessity if an appropriate IEP is to be developed within a reasonable time frame.

F. Program Planning

1. To call a Child Study Team (CST) meeting following the interdisciplinary evaluation. All persons or agencies responsible for implementing educational programs with the child should be in attendance. Minimally this would require the parents, the home visitor and the early childhood special education specialist to serve on the CST. In addition, if the child is receiving services through any other programs, agencies or private therapists, representatives of these services should also serve on the CST.
2. To facilitate a CST recommendation regarding permanent

program eligibility and to obtain signatures on the IEP concurring with placement and/or written and signed statements indicating dissenting opinions. At this time (or any time they so indicate) it is the parent's right to elect to discontinue participation. Although project staff members should do everything possible to adapt a program to fit the needs of the child and family, the parents' right to reject the services should always be respected. A home-based program cannot meet every family's needs.

3. To facilitate the CST's development of the IEP including the annual objectives and designating the specific educational responsibilities of each individual and/or agency. The parents should then prioritize these long-range objectives so that those objectives which they feel are of greatest importance will be given primary consideration. It is hoped that this will be a motivational factor in getting the parents to work systematically with their child. Assuring that the annual goals are written and prioritized and that the IEP is signed by the CST is the responsibility of the specialist.
4. To develop the accompanying IIP for the first quarter (approximately 12 weeks) and to specify behavioral objectives to be accomplished within the twelve-week period.

Copies should then be made available to the parents and the paraprofessional home visitor.

5. To assign the writing of the IIP to the center aide or home visitor. In addition the center aide may be responsible for developing the weekly lesson plans in accordance with the IIP or for assuring the appropriateness of those lesson plans developed by the home visitor.

G. Program Implementation

1. To supervise and monitor the program which is implemented with the child. By supervising directly and indirectly the work of the paraprofessional home visitors and by monitoring the parent's work with the child through records kept by the parents, the home visitor and the center aide; the specialist should be able to determine whether the child's program is being systematically implemented.
2. To monitor each child's performance and progress by maintaining appropriate communication with the home visitor and family.
3. To observe the parents during the monthly supervisory visit as they conduct the weekly lesson plan with the child and to take data on the cues and consequences used during the teaching activities. (Figure 7.17).

H. Program Evaluation

1. To evaluate (monitor) child performance data on a frequent

basis and to make program changes whenever the data so indicates. These recommendations should be communicated to the center aide and/or the paraprofessional home visitor directly.

2. To assure that reassessment on objectives for which programming took place is conducted quarterly (every twelve weeks) by the home visitor.
3. To develop the new IIP for the ensuing quarter based on the results of the reassessment. This may be assigned to the center aide, or home visitor, however, it should be closely examined by the specialist to assure appropriateness to the IEP.
4. To annually readminister the Alpern-Boll Developmental Profile to the child.

Responsibilities to the Paraprofessional Home Visitor of the Early Childhood Special Education Specialist

The responsibilities of the early childhood special education specialist for recruitment, selection, orientation, training, supervision and evaluation of the paraprofessional home visitors include the following:

A. Recruitment

1. To assure that all recruitment procedures are in compliance with Equal Employment Opportunity guidelines and that advertising related to the position is in compliance with these guidelines.

2. To contact advisory board members, community professionals, and parents of handicapped children to obtain names of potential home visitor trainees in their area.
3. To assure that interested applicants are given enough information about the position so that they will be able to make a decision about whether to apply.

B. Selection

1. To review all applications within the specialists' assigned region. Following the closing date for applications, the coordinator submits all applications within the specialist's geographic region to the specialist. The specialist then reviews each application and contacts all references listed by each applicant.
2. To arrange for the interview process based on the written application and recommendations of the references, the specialist then selects the top two or three applicants and arranges personal interviews with each. The interview provides the opportunity for each early childhood special education specialist and the coordinator to rank each applicant on ten different attributes.
3. To issue a Home Visitor Agreement to the top ranked applicant. Following the signing of the Home Visitor Agreement the specialist notifies the coordinator that the position has been filled.

C. Orientation

The specialist is responsible for meeting with the trainee for an orientation session.

1. To clarify dates, times and expectations of the home visitor trainee for the orientation assignments and the pre-service training session.
2. To clarify anticipated training expenses and reimbursement procedures.
3. To provide and explain materials to be read and/or completed prior to the pre-service training workshop.
4. To provide the training with opportunities to observe the administration of screening and assessment instruments as well as a home visit (optional).

D. Training

1. To select appropriate training objectives, activities, materials and evaluation procedures and to make necessary scheduling and travel arrangements for the pre-service training workshop.
2. To execute the pre-service training workshop with an emphasis upon assuring competency in as many areas as possible and to identify additional training needs for each trainee (Figure 7.18).
3. Following the pre-service training workshop, and periodically thereafter, to conduct a training needs assessment for all assigned paraprofessional home visitors. From supervisory activities and the training needs assessment, the specialists can make decisions about continued in-service training needs for the home visitor.

COMPETENCY ATTAINMENT PROFILE

Paraprofessional:

Orientation Date:

Supervisor:

Preservice Date:

County:

Inservice Dates:

OBJECTIVE

	1	2	3	4	5	6	7	8	9	10	11	12
1		=====	=====	=====	=====	=====	=====	=====	=====	=====	=====	=====
2							=====	=====	=====	=====	=====	=====
3						=====	=====	=====	=====	=====	=====	=====
4												
5										=====	=====	=====
6				=====	=====	=====	=====	=====	=====	=====	=====	=====

Figure 7.18 Competency Attainment Profile

4. To schedule, plan, implement and record in-service training sessions so that the home visitors' in-service training needs can be met in the most cost-efficient way (Figure 7.18). Possibilities for in-service home visitor training include the following:
 - a) individual sessions conducted by the specialist with an individual home visitor (e.g., the half-hour of training during supervisory visits),
 - b) part-day or full-day training sessions conducted by the specialist with all home visitors assigned to that specialist,
 - c) in-service workshops conducted at a demonstration site with all home visitors present.

E. Supervision and Evaluation

1. To supervise the home visitor's work with parents and children. In addition to the three joint home visits required--the initial home visit, the administration of the Alpern Boll Developmental Profile and the CST meeting to write the child's IEP -- the specialist is required to make periodic supervisory home visits with the paraprofessional home visitors. Initially it is advisable to schedule such supervisory visits monthly. After the home visitor obtains more experience, it may be possible to accompany them less frequently, eventually reaching a minimum of four supervisory visits annually.

2. During supervisory visits, the specialist accompanies the home visitor to one or more homes which they are serving and observes the home visitor's ability to conduct the visit in accordance with the model. The ability of the home visitor to interact with the child and the family members is also assessed. Following the home visit, the specialist fills out the Home Visitor Supervisory Report (Figure 7.19) and meets in a private staffing with the home visitor to discuss strengths and weaknesses demonstrated during the home visit and to identify in-service training needs with the home visitor.
3. To spend approximately one-half hour following the staffing to meet training needs which have previously been identified for the home visitor.
4. To check the files and records of the home visitor to assure that required data and information is being kept and that the files are complete and accurate.
5. To implement alternative or supplementary supervisory methods whenever direct supervision is infrequent or somehow insufficient. Alternative methods of supervision include the following:
 - a) Requesting permission from the family to have the home visitor tape record home visits. The tape is then submitted to the specialist for analysis, and telephone feedback to the home visitor is provided.

HOME VISITOR SUPERVISOR REPORT

Home Visitor Diane Smith

Supervisor Ann Murray

Date 2/26/79

Child's Name John Doe Location of Observation Doe Home

Purpose of Home Visit:

Was the Activity Completed?

The Home Visitor:

1. Observed parent's implementing previous week's activity.
2. Took post training data.
3. Provided parents with appropriate feedback on their cues and consequences.
4. Demonstrated new weekly lesson activity.
5. Provided parents with appropriate feedback on their cues and consequences for new activity.
6. Took pre-training data on new lesson activity.
7. Checked out new material in keeping with the lesson activity or IEP.
8. Checked on old materials.
9. Asked for data collected by parents.
10. Spent time with parents and family discussing objectives related to FEP.
11. Left time for parents to express concerns and ask questions.
12. Completed the Home Visitor Report form and left a copy with the parents.

No	Yes		Comments
	Inadequate	Adequate	
		✓	
	✓		no data on language activity
		✓	
		✓	
	✓		point out appropriate uses of cues and consequences
		✓	
		✓	
		✓	
		✓	
		✓	
		✓	

Strengths and Needs of Home Visitor (Note friendliness, responsiveness, rapport etc.)

Good modeling of language stimulation techniques. Work on positive feedback to parents.

Figure 7.19 Home Visitors Supervisory Report

- b) Videotaping a home visit by the center aid to take back to the specialist for analysis and feedback. This requires written parental permission. (Figure 5.1)
- c) Contacting the families served to get feedback regarding their satisfaction with services provided through the home visitor.

- 6. To annually request parents to complete a Parent Satisfaction Evaluation Form (Figure 6.18) which permits feedback from the parents on services provided through Project Sunrise.

Responsibility of Early Childhood Special Education Specialist to the Center Staff

The responsibilities of the early childhood special education specialist to the center aide include the following:

- 1. To help the center aide implement lending library procedures and to help assure that loan materials are delivered and picked up in contracts with the paraprofessional home visitors.
- 2. To assure that the data needed by the center aide in the collection and analysis process is obtained and is available to the center aide. The specialist is also responsible for the accuracy and appropriateness of any data reports prepared by the center aide.
- 3. To clearly specify duties to be performed and to orient the center aide in such a way that the responsibilities can be carried out.

4. To provide verbal and/or written feedback regarding strengths and needs to the center aide.

The following responsibilities outline the obligations of the early childhood special education specialists to each other:

1. To participate in joint program planning and to carry out responsibilities assigned during joint decision-making activities.
2. To assure that open and clear communication takes place during all stages of program planning, implementation and evaluation.
3. To develop and implement appropriate peer review procedures to assure that the model is implemented systematically by all of the specialists. On-site visitations and observations of home visitor conferences and/or training sessions should be included as part of the peer review process.
4. To maintain a log of professional contacts recording inter-agency meetings, important telephone calls and important staff meetings (Figure 7.20).

The following outlines responsibilities which each early childhood special education specialists has to the coordinator:

1. To provide the coordinator with requested data, information and reports which will permit program

- development and model evaluation.
- a. Information about the status of child and family services (Figure 7.21).
 - b. Information about budgetary expenditures of the para-professional home visitors which is compiled and submitted monthly (Figure 7.22).
2. To implement administrative policies, procedures and decisions communicated through the coordinator.
 3. To fulfill task assignments made by the coordinator.
 4. To obtain permission for vacation time and staff development experiences from the coordinator (Figure 7.23).
 5. To submit all requests for expenditures to the coordinator for approval.

The Coordinator

The position of the coordinator is an administrative position and the duties associated with it reflect its administrative nature. The coordinator is responsible for coordinating, supervising and evaluating staff development, for planning to assure program development and implementation, and for assisting in budget development and continued financial backing. These duties

LOG

Name: _____

Date: _____

Departure Time: _____

Log No. _____

Return Time: _____

Destinations: _____

Mileage: _____

Objectives

Contacts

Length of
Time

Summary:

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SUMMARY OF
MONTHLY SERVICE DELIVERY EXPENDITURES

Month _____

215

SPECIALIST

[illegible]

Total Number
Children/Families

Families Served

Indirect Service	
FEP	
IEP	
Direct Service	
Outcome	
Diagnostic Evaluation	
Actual or Suspected Handicapping Condition	
Entrance Date	
Entrance Criteria	
County	
Referred By	
Referral Date	
Birthdate	
Sex	
Child	

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PROJECT SUNRISE
VACATION REQUEST

Name: _____

Date: _____

Vacation requested for the following dates:

Approved by: _____

Date: _____

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are to be executed in addition to fulfilling the responsibilities of an early childhood special education specialist. Depending upon the administrative demands which are placed upon the coordinator, it may be necessary to limit the number of paraprofessional home visitors whom the coordinator can supervise.

The three administrative areas for which the coordinator is responsible are:

1. staff development
2. program planning and evaluation
3. budget development and fiscal responsibility

In addition to all competencies needed by parents, paraprofessional home visitors, center aides, and early childhood special education specialists, the coordinator needs competencies in the area of administrative skills (Figure 7.24).

Staff Development

The coordinator's responsibilities for staff development include:

1. To plan and chair regularly scheduled monthly staff meetings between the specialists. Special sessions may also be conducted as the coordinator identifies additional needs.
2. To identify staff development needs among the specialists and center aides and to make provisions for meeting and evaluating those identified needs (Figure 7.25).
3. To schedule and assure appropriate planning for tri-annual

Competency #1 - Administrative Skills

The coordinator will be able to coordinate, supervise and evaluate staff development, plan for program development and implementation, and assist in budget development and administration.

The coordinator will be able to:

1. Plan and conduct regularly scheduled staff meetings.
2. Identify staff development needs among the early childhood special education specialists and assure that those needs are fulfilled.
3. Plan, implement and evaluate hiring procedures to fill staff openings.
4. Make staff assignments that assure program growth and development.
5. Identify the fiscal needs of the developing program and prepare an appropriate budget.
6. Make recommendations to the Project Director for expenditures in keeping with the approved budget.
7. Implement local, state and federal reporting requirements.
8. Conceptualize future program development and plan for, monitor and evaluate that development to assure the success of the model.
9. Utilize the resources of the advisory board, the Project Director, the staff and outside personnel to help assure continued funding of the program.
10. Assure that advisory board meetings are scheduled planned and implemented and that the necessary minutes and information is distributed to the members.

I have no knowledge or skill	I have little knowledge or skill	I need more knowledge and skill before I could implement with assistance.	I have working knowledge (i.e., understanding) and/or ability to use with assistance and/or additional information	I have expert knowledge and/or skill to implement with proficiency
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

Figure 7.24 Competency (Coordinator)

PROJECT SUNRISE

EVALUATION OF STAFF DEVELOPMENT ACTIVITIES

Staff Person _____

Staff Development Activity _____

Date _____

SA - Strongly Agree
A - Agree

D - Disagree
SD - Strongly Disagree

NA - Not Applicable

SA	A	NA	D	SD	
☐	☐	☐	☐	☐	1. Participation in this activity was of benefit to me.
☐	☐	☐	☐	☐	2. Stated goals and objectives were accomplished.
☐	☐	☐	☐	☐	3. Enough time was allotted for this activity.
☐	☐	☐	☐	☐	4. This activity will help me to more competently function in my position.
☐	☐	☐	☐	☐	5. Participation in this activity will enhance my opportunities for career advancement.

This activity provided an opportunity for growth in the following areas:

Content	Implementation	Professional Growth
(Associated with concept and knowledge acquisition).	(Refers to those skills necessary to implement the Sunrise model and/or those skills necessary to be a staff person in a demonstration project).	(Refers to needs required by the individual staff person in order to grow professionally in their present position.)

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Figure 7.25 Evaluation of Staff Development Activities

advisory board meetings. In addition he/she is responsible for the accuracy of minutes and other information distributed to the advisory board.

4. To assure that appropriate hiring procedures are implemented in securing all staff members, including paraprofessional home visitors, center aides, early childhood special education specialists and secretaries. He/she is also responsible for assuring that appropriate procedures are followed in terminating an employee.
5. To make staff assignments and assure the quality and completion of those assignments.
6. To periodically schedule evaluative conferences with each specialist to provide feedback regarding their performance. This could be documented and a written summary of the major points of the conference placed in the specialists file. A copy of that summary should be given to the specialist.
7. To provide periodic opportunities for staff members to evaluate his/her performance as coordinator.

Program Planning and Evaluation

The coordinator's responsibilities for program planning and evaluation include the following:

1. To conceptualize future program development and planning needs. This requires being able to set long-and short-range objectives for the program and identifying the

resources of manpower, money, materials, time and authority needed to meet those objectives.

2. To assure that program evaluation procedures are implemented for every aspect of the program and that program evaluation data is available at the request of the public.
3. To implement local, state, and federal reporting requirements. This may include preparation of grants and periodic reports.

Budget Development and Fiscal Responsibility

The coordinator's responsibilities for budget development and fiscal responsibility include the following:

1. To identify the fiscal needs of the developing program and to prepare an appropriate budget. Planning to assure that the fiscal needs of the program are met and assuring that application for funding is made is also the responsibility of the coordinator and other administrative staff.
2. To approve necessary expenditures related to the program and assure that the program operates within the confines of the approved budget.

SUMMARY

In addition to the secretary, the center staff is comprised of staff members at three levels -- the center aides, the early childhood special education specialists and the coordinator. The center aide serves in a clerical role and may have technical assistance responsibilities to the paraprofessional home visitors.

In addition the center aides may assist in training of the paraprofessional home visitors. The center aide is responsible for the maintenance of the lending library and for collecting and organizing data related to the program.

The early childhood special education specialist is the special education teacher responsible for implementing appropriate programs with handicapped preschool children and their families. In addition, the specialist is responsible for the recruitment, selection, orientation, training, supervision and evaluation of the paraprofessional home visitors. The specialists are also ultimately responsible for the systematic implementation of the model and for program development related to the model. Therefore, they also have responsibilities to the center aides, the other specialists and the coordinator.

The coordinator, in addition to serving as a specialist, also has responsibility for administrative duties related to the program. These administrative functions include the areas of staff development, program planning and evaluation, and budget development and fiscal responsibility.

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A P P E N D I X A

Definitions

48-2.18(6)-S1860 HANDICAPPED CHILD. (1) "Handicapped child" means a child evaluated as being mentally retarded, hard-of-hearing, deaf, speech-impaired, visually handicapped, emotionally disturbed, orthopedically impaired, other health-impaired, or as having specific learning disabilities, who because of those impairments needs special education and related services. (History: Sec. 75-7801(2), R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(6)-S1870 DEAF. (1) "Deaf" means a hearing impairment which is so severe that the child's hearing is nonfunctional for the purpose of educational performance. (History: Sec. 75-7801(3), R.C.M. 1947; Order MAC No. 48-1, Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(6)-S1880 HARD-OF-HEARING. (1) "Hard-of-hearing" means a hearing impairment, whether permanent or fluctuating, which adversely affects a child's educational performance but which is not included within the definition of "deaf". (History: Sec. 75-7801(4), R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(6)-S1890 MENTALLY RETARDED. (1) "Mentally retarded" refers to a person with significant subaverage general intellectual functioning, which originated during the developmental period and who does not exhibit acceptable adaptive behavior. All three criteria must be met before a person is so classified. Subaverage general intellectual functioning is regarded as approximately 1.6 standard deviations below the population mean (I.Q. of approximately 75) for the age group involved as determined by an individual test of general intellectual functioning. (History: Sec. 75-7801(5), R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(6)-S18000 ORTHOPEDICALLY IMPAIRED.
(1) "Orthopedically impaired" means a severe orthopedic impairment which adversely affects a child's educational performance. The term includes but is not limited to impairment caused by congenital anomaly (e.g., clubfoot or absence of some member), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis) and impairments from other causes (e.g., fractures or burns which cause contractures, amputation, cerebral palsy). (History: Sec. 75-7801(6), R.C.M. 1947; Order MAC No. 48-1, Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(6)-S18010 OTHER HEALTH IMPAIRED. (1) "Other health impaired" means limited strength, vitality, or alertness due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle-cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes. (History: Sec. 75-7801(6), R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(6)-S18020 EMOTIONALLY DISTURBED. (1) "Emotionally disturbed" means a condition exhibiting one or more of the following characteristics to a marked degree and over a long period of time: an inability to learn which cannot be explained by intellectual, sensory or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms, pains or fears associated with personal or school problems. The term does not include children who are socially maladjusted. The emotionally disturbed category may include students who also may have been diagnosed by appropriate specialists as autistic, psychotic, sociopathic or schizophrenic. An emotionally disturbed child's disorders are not primarily the result of problems with visual acuity, hearing impairment, physical handicaps, cultural or instructional factors or mental retardation. "Emotionally disturbed" refers to a person who has been identified, based on a comprehensive evaluation, as having observable behavioral patterns which seriously inhibit the academic and social or emotional growth of the individual or the educational rights of others to the point that supportive services are required, these behavioral patterns may include:

(a) excessive physical or verbal aggression toward oneself or others and a lack of response to regular educational intervention;

(b) high frequency of persistent inattention to academic or social tasks associated with regular classroom performance; and

(c) persistent withdrawal from peer or adult interactions associated with the expected social development in a regular educational environment. (History: Sec. 75-7801(8), R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(6)-S18030 SPECIFIC LEARNING DISABILITY. (1) "Specific learning disability" means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical

calculations. The term includes but is not limited to such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing or motor handicaps, mental retardation or environmental, cultural or economic disadvantages.

(2) A learning disabled person is a person who has been identified as having the following characteristics:

(a) Functional. There must be a significant discrepancy between the person's potential or capacity and actual performance in one or more of the basic academic areas (reading, writing, language, spelling, mathematics, etc.).

(i) The discrepancy (difference) is typically measured in terms of: grade levels (years and months), specific deficits in skills assigned to a particular grade level or scores, or achievement performance data compared to actual grade placement, chronological or mental age, or some other indicator of capacity or potential.

(aa) The learning disabled child's competencies and individual strengths and weaknesses must be reviewed for discrepancies; however, the learning disabled student may not show discrepancies in all academic areas.

(ii) Assessment of discrepancy is accomplished through use of formal, informal and observational tools--all three processes are considered necessary.

(iii) Individual evaluation data must indicate that the child is capable of performing near, within or above the average range of learning potential (intellectual functioning).

(b) Psychological Process. "Psychological process" refers to receptive, integrative and/or expressive skills. A dysfunction in the psychological process must be shown in perception, discrimination, understanding, attention, recall, concept formation and the use of spoken and/or written language, and the ability to listen, think, read, speak, write and perform mathematical calculations.

(i) Comprehensive evaluation by qualified medical examiners may assign diagnostic labels such as dyslexia, aphasia, minimal brain dysfunction, perceptual impairment, etc. These medical evaluations may provide assistance in the determining process but are not required. (History: Sec. 75-7801(9), R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(6)-S18040 SPEECH/LANGUAGE IMPAIRED.

(1) "Speech/language impaired" means a communication disorder such as stuttering, impaired articulation, or a language or voice impairment which adversely affects a child's interpersonal relationships or educational performance. (History: Sec. 75-7801(10), R.C.M. 1947; Order MAC No. 48-1, Adp. 8/10/77; Eff. 8/25/77.)

48-2.18(6)-S18050

SUPERINTENDENT OF
PUBLIC INSTRUCTION

48-2.18(6)-S18050 VISUALLY HANDICAPPED. (1) "Visually handicapped" means a visual impairment which, after correction, adversely affects a child's educational performance. The term includes both partially seeing and blind children. (History: Sec. 75-7801(11), R.C.M. 1947; Order MAC No. 48-1; Adp. 8/10/77; Eff. 8/25/77.)

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A P P E N D I X B

PUBLISHED MATERIALS USED IN IMPLEMENTING THE PROJECT

SUNRISE MODEL

Alpern-Boll Developmental Profile. Psychological Development Publications, Aspen, Colorado, 1972.

Comprehensive Identification Process. Scholastic Testing Service: Bensonville, Illinois, 1975.

Curriculum Assessment and Monitoring System. Demco Educational Corporation, DeForest, Wisconsin, 1977.

Denver Articulation Screening Exam, Ladoca: Denver, Colorado, 1975.

Denver Developmental Screening Test. Ladoca: Denver, Colorado, 1975.

Denver Eye Screening Test. Ladoca: Denver, Colorado, 1972.

Denver Pre-Screening Developmental Questionnaire. Ladoca: Denver, Colorado, 1976.

Preschool Profile. Experimental Education Unit (WJ-10 College of Education and Child Development and Mental Retardation Center, University of Washington: Seattle, Washington, n.d.

Uniform Performance Assessment System. College of Education, Experimental Education Unit, Child Development and Mental Retardation Center, University of Washington: Seattle, Washington, 1978.

Published Materials Used to Train Project
Sunrise Home Visitors

Curriculum Assessment and Monitoring System Slide-tape presentation. Demco Educational Corporation: DeForest, Wisconsin, 1977.

Denver Developmental Screening Test training film. Ladoca: Denver, Colorado, 1975.

Early Learning; An Introduction to the Stages of Development in Infancy. High/Scope Educational Research Foundation: Ypsilanti, Michigan.
i

The Handicapped Child: Infancy Through Preschool. Concept Media, Inc: Irvine, California, 1978.

Portage Parent Program. Cooperative Education Service Agency 12: Portage, Wisconsin, 1977.

Supplementary Curriculum Materials

The following supplementary resources may be valuable in planning appropriate educational programs for children.

Behavior

Azrin, N. Foxx, R; Toilet Training in Less Than a Day. Simon and Schuster, New York, 1974.

Baldwin, V., Fredericks, H., Brodsky, G.; Isn't It Time He Outgrew This? or A Training Program for Parents of Retarded Children. Charles C. Thomas, Springfield, Illinois, 1976.

Jordan, J., Robbins, L.; Let's Try Something Else Kind of Thing - Behavioral Principles and the Exceptional Child. The Council for Exceptional Children, Arlington, Virginia, 1972.

Macht, J.; Teaching Our Children. John Wiley and Sons, Inc. New York, 1975.

Training in the Teaching Research Data Based Classroom Model. Teaching Research Infant and Child Center, Monmouth, Oregon.

When a Child Misbehaves. Outreach and Development Division of the Exceptional Child Center, Utah State University, Logan, Utah, n.d.

Stimulation

Baratta-Lorton, M.; Work Jobs. Addison-Wesley Publishing Company, Menlo Park, California, 1972.

Exploring Materials. The Media Resource Center of the Massachusetts Department of Mental Health Division of Mental Retardation, Boston, Massachusetts, 1974.

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Karnes, M.; Learning Language at Home. The Council for Exceptional Children, Reston, Virginia, 1977.

Painter, G.; Teach Your Baby. Simon and Schulster, New York, 1971.

Smith, B., Tucker, D., Finkelstein, A; Putting the Pieces Together... A Good Home Environment. Department of Mental Retardation, Piedmont Region, Whitten Village, Clinton, South Carolina.

Structured Learning Activities

Bluma, S., Shearer, M., Frohman, A., Hillard, J.; Portage Guide to Early Education. Portage Project, Cooperative Educational Service Agency, Portage, Wisconsin, 1976.

Coughran, L., Goff, M. Learning Staircase. Learning Concepts, Austin, Texas, 1976.

Developmental Activities. Department of Health, Education, and Welfare, Bureau of Education for the Handicapped (OEG-0-72-4501). Sewall Early Education Development Program, Sewall Rehabilitation Center, Denver, Colorado, 1975.

Fredericks, H., Riggs, C., Furey, T., Grove, D., Moore, W., McDonnell, J., Jordan, E., Hanson, W., Baldwin, V., Wadlow, M.; The Teaching Research Curriculum for Moderately and Severely Handicapped. Teaching Research Infant and Child Center, Charles C. Thomas, Springfield, Illinois, 1977.

Schirmer, G.; Performance Objectives for Preschool Children. Adapt Press, Inc. Sioux Falls, South Dakota, 1974.

Supplementary Curricular Materials

The following supplementary resources may be valuable in planning appropriate Family Educational Programs (FEP).

1. To increase parents' knowledge of normal child development patterns.

Cook, S.; Helping Children Grow. Washington County Children's Program, Machias, Maine, Downeast Graphics, Elsworth, Maine, 1977.

Griffin, P., Sanford, A.; Learning Accomplishment Profile for Infants. Chapel Hill Training Outreach Project, Kaplan Press, Winston-Salem, N.C., 1975.

Hurlock, E.; Child Development. McGraw-Hill Books Company, San Francisco, Ca. 1964.

2. To increase parents' knowledge of their child's handicapping condition and of handicaps in general.

The Exceptional Parent: Psy-Ed Corporation, Manchester, New Hampshire.

Haring, N.: Behavior of Exceptional Children. Charles E. Merrill Publishing Company, Columbus, Ohio, 1978.

Responding to Individual Needs in Head Start: Part 1, Department of Health, Education and Welfare, DHEW Publication No. (OHD) 75-1075, Washington, D. C. 1974

3. To increase parents' understanding of desirable parenting and child rearing practices.

Dobson, J. Dare to Discipline. Tyndale House Publishers, Wheaton, Illinois, 1976.

Gordon, T.: P.E.T. Parent Effectiveness Training. A Plum Book, The New American Library, Inc. New York, 1975.

Yankelovich, Skelly and White, Inc.: Raising Children in a Changing Society. The General Mills American Family Report, 1976-77, General Mills, Inc. Minneapolis, Mn. 1977.

4. To facilitate parent and family adjustment to the handicapped child.

The Exceptional Parent. Psy-Ed Corporation, Manchester, New Hampshire

Fallen, N., McGovern, J.: Young Children with Special Needs. Charles B. Merrill Publishing Company, Columbus, Ohio, 1978.

Heisler, V.: A Handicapped Child in the Family - A Guide for Parents. Grune and Stratton, Inc. New York, 1972.

A Parent's Guide to Child Development Resources. Child Development Resources, Williamsburg, Va. 1977.

5. To increase parent's knowledge of available community and governmental resources which would help the family cope.

Closer Look. National Information Center for the Handicapped, U.S. Department of Health, Education and Welfare, Office of Education, Bureau of Education for the Handicapped, Washington, D. C.

Sanford, A. Henley, H. Fabrizii, J., Watkins, S.: The 1977 Chapel Hill Study of Services to the Handicapped in Region IV Head Start. Chapter VI. Mobilization and Utilization of Resources. The Chapel Hill Training Outreach Project, The Loom Press, 1977.

6. To aid parents in observing and collecting data regarding their child's behavioral performance.

Boyd, R., Bluma, S.: Portage Parent Program, Cooperative Education Service Agency 12, Portage, Wisconsin, 1977.

Cliff, S., Gray, J., Nymann, C.: Mothers Can Help . . . A Therapist's Guide for Formulating a Developmental Text for Parents of Special Children. El Paso Rehabilitation Center, El Paso, Texas, 1974.

Craighead, W., Kazdin, A., Mahoney, M.: Behavior Modification Principles, Issues and Applications. Houghton Mifflin Company, Boston, Massachusetts, 1976.

Jordan, J., Robbins, L. Editors: Let's Try Doing Something Else Kind of Thing. The Council for Exceptional Children, Arlington, Virginia, 1972.

Mather, J.: Learning Can Be Child's Play. The Parthenon Press, Nashville, Tennessee, 1976.

Training for Independence Programs. Outreach and Development Division of the Exceptional Child Center, Utah State University.

7. To increase parents' teaching skills.

Concept Media, Inc., Irvine, Ca. 92714

Parent's Magazine Films, Inc.; Family Life Sound and Color Filmstrips. New York, N. Y.

Systematic Training for Effective Parenting; American Guidance Services, Inc., Circle Pines, Mn.

APPENDIX C

CRITERIA FOR MEETING HOME VISITOR COMPETENCIES

Competency #1 - The Project Sunrise Model

Objective 1:

Conditions: Following the completion of the programmed text:
"Understanding the Project Sunrise Model"

Trainee will: complete post-test covering the objectives outlined in Competency area #1

As measured by: 80% accuracy on the post-test

Competency #2 - Identification and Screening

Objective 1

Conditions: Following the preschool observation and reading of developmental information

Trainee will: use the Characteristic Behavior Form to describe 1 developmental milestone in the area of pre-academic, motor communication, self-help and social-emotional skills for each of six age levels (birth to 12 months, 12-24 months, 24-36 months, 36-48 months, 48-60 months, 60-72 months).

As measured by: completed Characteristic Behavior Form to trainer satisfaction

Objective 2

Conditions: Given pre-service training

Trainee will: list and describe the primary purposes of early and periodic screening

As measured by: at least two listed purposes of trainer satisfaction

Objective 3

Conditions: Given practice with a child during pre-service training

Trainee will: complete one Denver Developmental Screening Test during in-service training with a real child or by observing a video taped administration of the DDST

As measured by: 80% reliability on trainer's score sheet

Objective 4

Conditions: Given observation of the administration of the Denver Articulation Screening Test with a child during preservice training.

Trainee will: score one Denver Articulation Screening Test

As measured by: 80% reliability on trainer's score sheet.

Competency #2 continued

Objective 5

Conditions: Given observation of the administration during pre-service training of the Denver Eye Screening Test

Trainee will: score one Denver Eye Screening Test (video taped)

As measured by: 80% reliability on trainer's score sheet

Objective 6

Conditions: After observing an actual inservice home visit or video taped home visit

Trainee will: identify and describe at least one home condition and one parent-child interaction pattern which might indicate conditions of risk to the child.

As measured by: at least one home condition and one parent-child interaction pattern to trainer satisfaction as recorded on competency Activity Record

Competency #3 - Assessment

Objective 1

Conditions: After appropriate presentations and practicums during pre-service training

Trainee will: define the relationship between screening, assessment, evaluation and instructional activities for preschool children

As measured by: verbal description to trainee satisfaction as recorded on Competency Activity Record

Objective 2

Conditions: Given pre-service training and inservice training

Trainee will: administer and score the motor, social-emotional and self-help of the CAMS and the pre-academic and communication portions of the UPAS assessment

As measured by: 90% reliability with supervisor's score sheet

Competency #3 Continued

Objective 3

Conditions: Given pre-service training and inservice training

Trainee will: explain the results of the CAMS/UPAS assessment administered for Objective 2 clearly defining the performance in each developmental area

As measured by: trainer satisfaction

Objective 4

Conditions: Given pre-service training and inservice training. and after observing a video taped home visit, and/or participating in an actual home

Trainee will: complete the Home Observation for Measurement of the Environment instrument

As measured by: 80% reliability with supervisor's score sheet

Objective 5

Conditions: Given pre-service training

Trainee will: describe the reason for assessment in the five developmental areas as it relates to normal growth and development

As measured by: verbal description to trainer, satisfaction as recorded on Competency Activity Record (CAR)

Competency #4 - Family Education Plan

Objective 1

Conditions: Given nine written characteristics and after viewing appropriate film strips during inservice training

Trainee will: match to the appropriate handicap

As measured by: 7/9 correct answers

Objective 2

Conditions: Given role play situations and/or appropriate audio-visual materials such as video tapes or film strips

Trainee will: during inservice training list family needs

As measured by: 30 or more listed needs (at least one need per role play situation)

Competency #4 Continued

Objective 3

Conditions: Given the three role play situations in Objective 2

Trainee will: during inservice training list needs which the family has for their handicapped child.

As measured by: at least one listed need per role play situation

Objective 4

Conditions: Given the three role play situations in Objective 2

Trainee will: during inservice training list possible effects of the handicapped child upon parents, siblings, and/or extended family

As measured by: written description of at least one listed effect

Objective 5

Conditions: Given the three role play situations in Objective 2

Trainee will: during inservice training list possible effects of parents, siblings, and/or extended family upon the handicapped child

As measured by: written description of at least one effect

Objective 6

Conditions: Given an actual home visit with the supervisor

Trainee will: identify appropriate and inappropriate cues and consequences provided by parents

As measured by: at least one inappropriate and one appropriate cue and one inappropriate and one appropriate consequence to trainer satisfaction

Objective 7

Conditions: Given pre-service and inservice training

Trainee will: complete the CAMS data sheet

As measured by: 80% reliability with supervisor's data sheet

Competency #4 Continued

Objective 8

Conditions: Given appropriate materials and inservice training

Trainee will: make activity/game and describe the skills which this material could be used to teach

As measured by: at least one completed activity/game

Objective 9

Conditions: Given a written situation during inservice training

Trainee will: describe how the parent could use the situation as a child-teaching opportunity

As measured by: trainer satisfaction

Objective 10

Conditions: During a five-minute interaction with a young child

Trainee will: demonstrate modeling and/or expansion techniques

As measured by: the use of the techniques at least three times per minute on 4/5 trials

Objective 11

Conditions: Given a role play situation

Trainee will: identify the active listening techniques used

As measured by: the identification of at least 3 of these techniques

Objective 12

Conditions: Following a home visit during inservice training

Trainee will: list conditions which are indicative of a child-centered learning environment (i.e., child-sized equipment, books, etc.)

As measured by: at least three listed conditions matching those listed by supervisor observing home visit

Competency #5 - Child Program Planning and Implementation

Objective 1

Conditions: Given a sample IEP and an accompanying CAMS/UPAS assessment

Trainee will: choose three weekly lesson plan activities to meet three different goals on the IIP

As measured by: trainer satisfaction

Objective 2

Conditions: Given a role play situation

Trainee will: demonstrate and explain the three chosen weekly lesson activities

As measured by: trainer satisfaction

Objective 3

Conditions: Given descriptions of possible handicaps and entry and terminal behavior during inservice training

Trainee will: task analyze one behavior into at least 5 written steps

As measured by: completion of written task analysis

Objective 4

Conditions: Given a selection of available material

Trainee will: select or describe appropriate toys, materials or equipment needed to implement each of the three weekly lesson plan activities

As measured by: selection of one appropriate toy/set of materials per lesson plan

Objective 5

Conditions: Given three weekly lesson plan activities

Trainee will: outline an optimum time, a location and/or a positioning that comprises the best educational setting for implementing each of the three weekly lesson plan activities

As measured by: at least two descriptors (time, location, positioning) per activity

Competency #5 continued

Objective 6

Conditions: Given an actual home visit during inservice

Trainee will: model and/or demonstrate the provisions of direct and indirect feedback to parents regarding their cues and consequences

As measured by: the use of at least one incident of feedback to trainer's satisfaction

Objective 7

Conditions: Given the skill level of a parent during inservice training

Trainee will: demonstrate the modification of the data collection procedure

As measured by: trainer satisfaction

Objective 8

Conditions: Following a home visit accompanied by supervisor

Trainee will: complete a home visitor report form

As measured by: trainer satisfaction

Competency #6 - Legal Rights

Objective 1

Conditions: Given written information on legal rights

Trainee will: during inservice training, verbalize 4 basic rights guaranteed a preschool handicapped child and their family through PL 94-142 and Montana House Bill 816

As measured by: trainer satisfaction

Objective 2

Conditions: Given written information on family confidentiality

Trainee will: during inservice training, list or verbalize three important procedures which will aid in assuring family confidentiality.

As measured by: trainer satisfaction

Competency #6 continued - Legal Rights

Objective 3:

Conditions: Given a role play situation

Trainee will: during inservice training, explain due process
 procedures applicable to parents

As measured by: trainer satisfaction

PROJECT SUNRISE

The Paraprofessional Home Visitor Training Program

The paraprofessional home visitor training program is comprised of three segments. The first segment is the orientation training which occurs during the two weeks prior to the pre-service training workshop. An orientation meeting is held between the home visitor trainee and the assigned early childhood special education specialist. At this time the orientation assignments are made and the training materials delivered. These materials include copies of the motor, self-help and social-emotional portions of the Curriculum Assessment and Monitoring System (CAMS) and the pre-academic and communication portions of the Uniform Performance and Assessment System (UPAS), the programmed text, Understanding the Project Sunrise Model, and the preschool observation packet. The trainee is instructed to complete the programmed text prior to the preservice workshop and to be prepared to take a post-test. Trainees are also requested to become familiar with the CAMS and UPAS materials. In addition, arrangements are made for the trainee to spend two and one half (2½) hours on three separate days observing in a local preschool. On one day, preferably the first, the assigned specialist accompanies the trainee to enhance the observation experience and to observe the trainee's ability to enhance the observation experience and to observe the trainee's ability to interact with young children and adults. If possible the trainee also is given the opportunity to observe the supervisor administering the screening and assessment instruments and may accompany the supervisor on the actual home visit.

The second training segment is the pre-service training workshop which is a three-day session held at the demonstration site at Eastern Montana College in Billings. The purposes of this workshop are to train the home visitors in the implementation of the model, to help establish a support network among the home visitors, and to give the trainees a better understanding of the total system in which they will be working.

The third training segment is the in-service training program which occurs following the pre-service training session. The purpose of the in-service training program is to assure that each home visitor reaches criteria on each competency objective. In-service training experiences may include individual sessions conducted by the specialist with a home visitor, part-day or full day sessions with several home visitors, or in-service workshops at a demonstration site with all home visitors present. Following pre-service training a home visitor enters one of the two in-service training tracks. The first track prepares a home visitor to take over one family currently being served by a specialist, and the in-service training assignments are designed to assure that the trainee is competent to meet the needs of that specific family as quickly as possible. The second track is entered if no families are waiting for services. This track assures that the trainee meets the competency criteria prior to serving a new referral.

UNDERSTANDING THE PROJECT SUNRISE MODEL

A Programmed Text for Paraprofessional
Home Visitors

PROJECT SUNRISE
Institute for Habilitative Services
Eastern Montana College
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Experimental Version
December 1978

300

Effective use of this book can best be accomplished by following these instructions:

- 1) Cover the answer portion of the page with a piece of paper or a marker.
- 2) After you have written your answer in the appropriate blank, slide the paper down to expose the correct answer.
- 3) Read each frame carefully. Easy frames lead to more advanced learnings.

UNDERSTANDING THE PROJECT SUNRISE MODEL

Project Sunrise is a federally funded grant.

1. The _____ government funds Project Sunrise.

This grant is one of the Handicapped Children's Early Education Program (HCEEP) grants.

1. federal

2. HCEEP grants refer to programs funded by the _____
_____ Early Education Programs. Together the programs are sometimes known as the First Chance Network.

2. Handicapped
Children's

3. The _____
_____ is another name for those grants funded under the Handicapped Children's Early Education Programs. There are approximately 200 of these grants throughout the nation, each of which is responsible for developing an appropriate educational model for serving preschool handicapped children.

3. First Chance
Network

4. Each First Chance Network grant is responsible for developing an appropriate educational _____ for serving young children with special needs. A model is an exemplary (example) program which school districts or other agencies can replicate (copy and use).

4. model

5. An _____ educational program which could be replicated or used by a school district or other agency is called a model. Models for educating preschool children are generally of three types -- 1) center-based, 2) home-based, or 3) combination center-home based. A center-based program provides children or parents or both with a classroom where people work together in groups.

5. exemplary
or example

6. When children or parents or both work together in a _____ setting the model is considered to be center-based. A home-based program provides a home visitor who goes into the home to work together with the parents and children of an individual family.

6. classroom
group

7. When a home visitor goes into the family's home to work with the parents and children, the model is considered _____-based. A combination program offers some group experiences in addition to home visits.

7. home

8. A _____ center-home based program provides experiences both in a classroom group as well as individually at home. All models have advantages. One advantage of a center-based program is that it provides social experiences for children or parents or both.

8. combination

9. Allowing children or parents or both the opportunity to come together to share in social situations is a major advantage of _____-based programs. One disadvantage is that, although children make significant gains in center programs, those gains are often not maintained longer than a year or two.

9. center

10. Gains made by preschool children in center-based programs are often not _____ longer than a year or two, an effect which is sometimes called "wash-out." Better long-range effects have been found in home-based programs where gains made are usually evident through the early primary grades.

10. maintained

11. Studies have indicated that preschool children who participated in home-based programs are able to maintain their gains through the _____ grades. One disadvantage is that a home-based program does not generally provide many social experiences for either parents or children.

11. primary

12. One disadvantage of a home-based program is that it does not usually provide many opportunities for parents and children to meet _____ with others. However, an important advantage is that a home-based program allows complete individualization to meet the needs of each child and family. ("Individualization" is the changing of a program to meet the unique needs of the individual or person served). In a home-based program the teaching plan for both the parents and the child can be individualized.

12. socially or together

13. _____ of the teaching programs for the parents and children is an important advantage of home-based programs, since this allows for the special needs of each family member to be met. Also home-based programs do not require finding a number of children of approximately the same age and developmental level who live close enough together to meet for a center-based classroom.

13. Individualization

14. A center-based classroom requires that several children of approximately the same age and developmental level live close together. The fact that children of different ages and levels of _____ living in widely separated geographic areas, can be served by a home-based program is another advantage. It is also sometimes easier to send a teacher into the home than to transport (bus) young children or their parents or both into a center.

14. development

15. An advantage of home-based programs is that it is often easier to arrange for a teacher to drive to the home than to _____ young children to a center. One of the most important advantages is that the parents maintain the educational responsibility for their young child. No other person can be assumed to be responsible for teaching the child.

15. transport or
bus

16. When a home-based program is used, parents maintain the _____ for the education of their young child. A home-based program then helps train the parents to be teachers for that child. The parents will be teaching their child skills during the next fifteen to twenty years of the child's life.

16. responsibility

17. Home-based programs teach parents how to be _____ of their young child, helping the child to learn new skills over many years. Parents can be taught how to provide their child with good educational experiences at home.

17. teachers

18. Preschool children can be given good _____ experiences at home if their parents receive the needed help and training. Parents may also need help in developing better parenting skills.

18. educational

19. Sometimes a home visitor works with the parents to help them develop better _____ skills. Parenting skills are those skills which parents need in order for them to help their child become an independent person who has the abilities to cope in our society.

19. parenting

20. In order to help a child develop independence and an ability to cope in our society, the parents need good parenting _____. Perhaps the most important advantage of home-based educational models is that, by training the parents, they help improve the quality of the child's home. Some educational experts believe that nothing which schools or teachers can do will help a child overcome shortcomings in the home. Therefore, changes must be made in the quality of homes in which young children live. Home-based programs can help to make the necessary changes.

20. skills

21. Some experts believe that _____ that teachers or schools can do will help a child overcome shortcomings in the child's home. Home-based programs can help make changes in the quality of the young child's home.

21. nothing

22. Home based models have the following advantages:

- 1) gains made by children are maintained throughout the early primary _____

- 2) educational programs can be _____
to meet the unique needs of children and families.
- 3) children of different _____,
developmental levels and from different geographic
_____ can be served in the same
program.
- 4) it is sometimes easier to send a teacher to the home
than to transport children and/or their parents to
a _____.
- 5) parents maintain the educational responsibility for
their child's early _____.
- 6) changes can be made in the _____
of a young child's home.

22. 1) grades or years
2) individualized
3) ages, areas
4) center
5) development
6) quality

23. Project Sunrise serves children at home. Therefore it
is considered a _____ - _____ model. It's
purpose is to serve young children who live in rural
areas of Montana.

23. home-based

24. This model will allow services to be delivered to young
children in _____ areas of the state.
A child must fall in the age-range of birth through six
years in order to be eligible to receive services.

24. rural

25. When a child reaches his or her _____ birth-
day, he or she is no longer eligible to receive services
through Project Sunrise. A child receiving services through
this program must exhibit signs of having "special needs"
or must have a handicapping condition.

25. seventh

26. A child must have a _____ condition or show signs of having special _____. In addition the child's parents must be willing to work daily with the child.

26. handicapping needs

27. A child must be handicapped or have special needs. In addition, Project Sunrise will only serve children whose _____ agree to work with their child for a short time each day. The parents are taught the skills which they need to teach their special child during a home visit by a paraprofessional home visitor.

27. parents

28. A paraprofessional _____ trains the parents in those skills which they will need to work with their own child. A paraprofessional is someone who has limited training and works with a professionally trained person.

28. home visitor

29. A person who works with a professional and who has limited training is called a _____. Another home-based program, the Portage Project in Portage, Wisconsin, found paraprofessionals to be even more effective than professionals as home visitors.

29. paraprofessional

30. The _____ Project, a home-based program located in Portage, Wisconsin, found that paraprofessional home visitors were more effective than the professional home visitors in working with parents. The Project Sunrise model uses paraprofessional home visitors who work with a professionally trained early childhood special education specialist.

30. Portage

31. The professionals in the Project Sunrise model are called early childhood _____ specialists. People holding this position are trained in both early childhood education and special education.

31. special education

32. The professionals working in Project Sunrise have training in both _____ education and special education. It is their responsibility to plan appropriate programs to help young children with special needs develop skills.

32. early childhood

33. The early childhood special education specialists are responsible for planning programs that help young children learn needed _____. It is, however, the parents who actually implement these programs by teaching their child for a brief period of time each day.

33. skills

34. The _____ actually teach the child the needed skills by working with their child daily for a brief period of time. In order to learn how to be a teacher of their own child, the parents work weekly with a paraprofessional home visitor.

34. parents

35. The parents learn teaching skills during a visit from a paraprofessional home visitor who comes once each _____. The paraprofessional teaches the parents how to recognize appropriate and inappropriate behaviors exhibited by the child.

35. week

36. During the home visit parents are taught how to recognize the appropriate and inappropriate _____ of their young child. They are also taught how to give the child cues so that the desired behavior occurs.

36. behaviors

37. The parents are taught how to give their young child appropriate _____ so that the desired behavior occurs. They are also taught how to correctly consequent (follow up) a behavior after it occurs. 37. cues
-
38. The paraprofessional home visitor also helps the parents learn to correctly follow-up or _____ a behavior. In addition, the parents are usually taught how to keep data or records on the child's performance. 38. consequate
-
39. _____ or records are generally kept by the parents to show how well the child performed. The parents also need to learn to recognize cues and consequences used by the child in changing the behavior of other family members. 39. Data
-
40. Children also provide _____ and _____ which change the behavior of other family members. Parents must learn to recognize these. The use of appropriate cues and consequences to change behavior and keeping data to show that behavior change is taking place are steps in behavior modification. Project Sunrise is based on a philosophy of teaching children with special needs by using behavior modification techniques. 40. cues and consequences
-
41. Because Project Sunrise teaches parents to use _____ modification in teaching their child, it is considered a behavioral model. Like all preschool programs, Project Sunrise must assure that the developmental sequences are followed. 41. behavior
-

42. Child development proceeds according to a certain developmental _____. Generally child development is seen as occurring in five specific areas: motor, language, preacademic, social-emotional, and self-help.

42. sequence

43. Child development is often broken into _____ areas. The first area is the motor area which refers to muscle activity in both the large muscles (gross motor) and the small muscles (fine motor). Gross motor activity includes jumping, running, climbing and hopping. Fine motor activity includes writing, coloring, cutting and pasting.

43. five

44. Two areas of motor development are _____ motor, which refers to the use of the small muscles, and _____ motor which refers to the large muscle. Language is also broken into two areas. Receptive language comes first and refers to understanding what is heard. Expressive language follows and refers to being able to communicate thoughts and ideas to others using words.

44. fine
gross

45. A child must first have _____ language (understanding) before thoughts and ideas can be spoken (_____ language.) The third area of child development is the preacademic (cognitive) area which refers to those skills needed by the child before he or she can read and do arithmetic. It includes shape sorting and symbol recognition, as well as matching colors and counting.

45. receptive,
expressive

46. Pre-reading and pre-arithmetic skills are sometimes referred to as _____ or cognitive skills.

The fourth skill area is the social-emotional area which refers to the ability of the child to get along with adults and other children, to play alone or with others, and to respond to problems which arise.

46. preacademic

47. _____ skills refer to the child's ability to solve social problems and to interact with other people. The last area of child development includes self-help skills, those skills which lead to independent living. Self-help skills include eating, dressing, toileting, and personal hygiene (tooth-brushing, hair combing, etc.)

47. social-emotional

48. Skills that contribute to a child's independence, such as being able to eat and dress alone, are known as _____ skills.

48. self-help

SUMMARY

49. A para-professional home visitor teaches the parents:

- 1) how to recognize appropriate or inappropriate _____ exhibited by the child,
- 2) how to provide appropriate _____ so the desired behavior will occur,
- 3) how to follow-up a behavior with the appropriate _____,
- 4) how to recognize _____ and consequences used by the child in changing the behavior of other family members, and
- 5) how to collect _____ or keep records of the changes in the child's behavior.

In addition, the paraprofessional home visitor helps parents see their child's development as it occurs in five different areas:

- 6) gross and fine _____ skills refer to the skills needed to execute movement of the large and small muscles,
- 7) _____ and _____ language refer to understanding words spoken by others and being able to speak one's thoughts and ideas,
- 8) skills in the _____ area prepare a child for reading and arithmetic,
- 9) responding appropriately to other children and adults require skills in the _____ - _____ area , and
- 10) _____ - _____ skills prepare the child with the skills needed to live independently.

49.

- 1) behavior
- 2) cues
- 3) consequences
- 4) cues
- 5) data
- 6) motor
- 7) receptive,
expressive
- 8) pre-academic
- 9) social-emotional
- 10) self-help

The steps in serving a child through the Project Sunrise model include the following:

- 1) referral
- 2) screening
- 3) assessment
- 4) The Family Education Program (FEP)
- 5) diagnostic evaluation
- 6) The Individualized Educational Plan (IEP)

7) The Individualized Instructional Plan (IIP)

8) Reevaluation

The first step in serving a child is to receive a referral by phone or mail from the parents or a professional in the community who expresses concern about a child.

50. When the center staff receives a _____ from the parents or a professional, they learn the name and some information about a child who may have special needs. The specialist then contacts the family and the home visitor to arrange a screening at a time convenient to them and to the assigned specialist.

50. referral

51. A _____ is arranged at the convenience of the parents, the home visitor and the early childhood special education specialist. One screening instrument often used by Project Sunrise is the Denver Developmental Screening Test (DDST). This is usually administered by the home visitor in the presence of the parents and the specialist during the first home visit.

51. screening

52. A _____ Developmental Screening Test is often used to determine whether the child appears to need a more in-depth evaluation. If the Denver indicates a "questionable" or "abnormal" score, the child will be considered temporarily eligible for services through Project Sunrise, and arrangements will be made for a more comprehensive evaluation.

52. Denver

53. If the score on the Denver is either _____
or _____ the child will be considered
eligible for services through Project Sunrise. If many
children are screened at one time, the Comprehensive
Identification Process (CIP) may be used. A "rescreen"
or "evaluate" score on the CIP will make the child
temporarily eligible for further services and will warrant
a more in-depth evaluation. The CIP is a group (mass)
screening instrument.

53. questionabl
abnormal

54. "Rescreen" or "evaluate" results on the _____
may also make a child eligible for Project Sunrise
services. A child may also be considered eligible if a
number of professionals working with the family feel that
the child is at risk of requiring special education ser-
vices when he or she goes to school.

54. CIP or
Comprehensive
Identification
Process

55. Project Sunrise also serves children who are thought by
a number of professionals to be _____
of requiring special education services when they enter
school.

55. at risk

SUMMARY

56. Three ways in which a child is considered temporarily
eligible for Project Sunrise services is by:

- 1) receiving a _____ or _____
score on the Denver Developmental Screening Test
- 2) receiving a _____ or _____
_____ score on the CIP or,

3) being considered at risk of requiring _____
_____ educational services when the child
goes to school.

56.
1) questionable,
 abnormal
2) rescreen, evaluate
3) special

If the results of the screening so indicate, temporary intervention begins. Intervention refers to all actions which are taken to help the child and family. This action is considered temporary since a more in-depth evaluation may indicate that the child does not have special needs.

57. When steps are taken to help a child and/or family,
_____ begins to take place. If the
results of the screening indicate that intervention is
needed, the specialist then takes steps to arrange for
a team of professionals to do a diagnostic evaluation.

57. intervention

58. If the screening suggests that the child may have special
needs, the specialist will request an in-depth diagnostic
_____ by a team of trained professionals.
While waiting for the diagnostic evaluation to be completed,
the parents and home visitor begin working together to
complete the functional skills assessment. This assess-
ment helps those responsible know which skills the child
has or has not acquired.

58. evaluation

59. In order to know which skills a child has acquired as well
as which skills have not been mastered, a functional skills
_____ is conducted. Another part of the assess-
ment procedure is to determine how the parents interact
with the child when they are together. This is called
the parent-child interaction pattern.

59. assessment

60. That portion of the assessment which helps determine how well a parent interacts with their child, assesses the _____ pattern. The instrument which Project Sunrise uses for this portion of the assessment is called the Home Observation for Measurement of the Environment.

60. parent/child interaction

61. The _____ is used by Project Sunrise to assess the parent-child interaction pattern. Following the assessment the parents are taught how to keep baseline data, information about their child's performance before a teaching program is begun.

61. Home Observation for Measurement of the Environment

62. Information about a child's performance before a teaching program begins is called _____ data. This information helps the professional evaluation team better understand the child's performance.

62. baseline

63. Baseline _____ gives the members of the evaluation team additional information about what the child typically can do. Baseline data is often collected as part of the Family Education Program (FEP), which outlines the educational goals that the home visitor has for the parents and other family members.

63. data

64. Educational goals for the parents and other family members are a part of the _____. The FEP may help the parents better understand normal child development, their child's handicapping condition, governmental and community resources, or may help them develop better parenting or teaching skills.

64. Family
Education
Program

65. The purpose of the _____ is to outline the educational needs which parents have in order to become better parents and teachers of their own handicapped child. As soon as possible after the FEP is implemented, the Project Sunrise early childhood special education specialist schedules a diagnostic evaluation for the child.

65. Family
Education
Program

66. A _____ evaluation is conducted by a team of professionals who are trained in various areas. Each professional evaluates the child from their own background or discipline, such as speech pathology, occupational therapy, physical therapy, audiology, psychology or medicine. The evaluation is conducted by an interdisciplinary team of which the parents are a part.

66. diagnostic

67. The _____ serve as members of the diagnostic evaluation team which is composed of professionals from a number of different disciplines. Following the evaluation the Child Study Team (CST) meets to formulate plans for serving the child.

67. parents

68. The _____ (CST) is composed of those people who are responsible for providing the child with appropriate educational services. This may be only the Project Sunrise supervisor, the home visitor and the parents. If the child receives speech therapy, the speech clinician will be a part of the CST. If the child attends a Head Start or nursery school, the teacher of the program will also be included.

68. Child Study Team

69. Those adults who hold the responsibility for meeting the child's _____ needs are members of the CST. The CST is charged with developing long-range and short-range goals in an Individualized Educational Plan. (IEP)

69. educational

70. The annual and short-range educational goals for a handicapped child are outlined by the _____ (IEP). One part of the IEP is the Individualized Instructional Plan (IIP) which outlines the objectives for a twelve week period. A new IIP is written every three months.

70. Individualized Educational Plan

71. Short-term objectives which can be accomplished within a _____ month period are recorded on the IIP.

Weekly lesson plans are developed from the IIP so that each short-term objective can be reached by the end of the twelve-week period.

71. three

72. The goals listed on the IIP are translated into _____ lesson plans (weekly objectives).

The paraprofessional home visitor instructs the parents in how to implement the weekly lesson plan.

72. weekly

73. When the new lesson activity is brought to the home, the paraprofessional _____ instructs the parents in techniques to use in implementing the activity. It is actually the parents who are the focus of the home visit.

73. home visitor

74. The home visitor focuses the purpose of the home visit on teaching the _____, who in turn teach their own child. The parents do the lesson activity daily with their child.

74. parents

75. The parents implement the lesson activity with the child each _____. Sometimes there will be two or three lesson activities on which the parents are working each day.

75. day

76. A child may be given more than _____ weekly objective (lesson plan) on which the parents work. During the home visit, the home visitor models (demonstrates) how to do the new activity with the child.

76. one

77. The home visitor _____ or demonstrates the teaching techniques which the parents are to use in implementing the daily lesson activities. The home visitor then observes the parents doing the lesson activity with their child and takes pre-training data on the child's performance. This helps the home visitor know how well the child can perform before instruction starts.

77. models

78. _____ data is taken in order to know how well the child can do prior to teaching activities. The next week the home visitor again observes the parents doing the activity with the child to see how well the child performs after training. This is known as post-training data.

78. Pre-training

79. Data taken after a week of teaching activities is known as _____ data. While observing the activities, the home visitor also notes the parent's use of appropriate cues. Cues (or antecedents) are what the adult does prior to the child's performance.

79. post-training

80. Antecedents or _____ are the words or gestures that the adult uses before the child performs the activity to help assure that the child responds correctly. The child's performance is called the behavior.

80. cues

81. The cue precedes the child's _____ or performance. What the adult does after the behavior is known as the consequence. The consequence can either increase or decrease the likelihood of the behavior occurring again.

81. behavior

82. The _____ are what the adult does following the child's behavior which either increase or decrease the likelihood of the behavior occurring again. A reinforcer increases a child's behavior.

82. consequences

83. When a consequence increases the child's behavior, it is said to be a _____. If it decreases the child's behavior, it is called an extinguisher.

83. reinforcer

84. A consequence that decreases the child's behavior is called an _____. While observing the parents teaching the activity, the home visitor takes data on the appropriateness of the parents' cues and consequences.

84. extinguisher

85. In addition to the pre-and post-training data on the child, the home visitor also takes data on the _____ of the cues and consequences used by the parents. During the home visit old teaching materials are checked in and new materials are checked out to the family.

85. appropriateness

86. The home visitor checks in the old instructional _____ and checks out new materials to the parents. Every three months the child is reevaluated (reassessed) and a new IIP is written to help meet the annual goals of the IEP.

86. materials

87. A _____ of the child is conducted every twelve weeks and new short-term instructional objectives are written. Annually a new IEP is written for the child.

87. reevaluation

88. Each _____ new long-term goals are written
for the child on a new IEP.

88. year

89.

SUMMARY A

The Child Intervention Procedure

- 1) _____ helps to identify those children who need more in-depth evaluations and makes a child temporarily eligible for Project Sunrise services.
- 2) _____ of the child determines the functional skill level at which a child is performing.
- 3) During the _____ the parents are taught to observe their child and take baseline data.
- 4) When the diagnostic _____ team is able to evaluate the child, the parents are able to provide data regarding the typical performance of their child.
- 5) The _____ Team (CST) is responsible for developing the Individualized Educational Plan (IEP) which outlines the annual educational goals for the child.
- 6) One part of the IEP is the _____ Plan (IIP) which designates short-term instructional objectives to be completed within a twelve-week period.
- 7) The weekly _____ plan activities are taken from the IIP and outline the goals that the child is to meet within the week.

- 8) A new IIP is rewritten every three months following the _____ and a new IEP must be written annually.

89

89.

- 1) Screening
- 2) Assessment
- 3) Family Education Program
- 4) evaluation
- 5) Child Study
- 6) Individualized Instructional
- 7) lesson
- 8) reevaluation

SUMMARY B

90.

The Parent (Family) Intervention Procedure

- 1) The _____ (FEP) outlines the educational goals which staff members have for parents and other family members.
- 2) The focus of the home visit is always upon the _____ rather than the child.
- 3) The home visitor observes the parents teaching the previous week's lesson activity with the child and takes _____ data on the child's performance.
- 4) The home visitor then _____ (demonstrates) the new lesson plan for the parents.
- 5) The home visitor observes the parents using the new lesson plan with the child and takes _____ data on the child's performance (behavior).
- 6) The home visitor also takes data on the appropriateness of the parent's _____, those words or actions which occur prior to the child's performance.

7) In addition, the home visitor also takes data on the _____ which the parents use following the child's performance to reinforce (increase) or extinguish (decrease) the child's behavior.

8) The home visitor checks in the old _____ materials and checks out new materials to the parents.

90.

- 1) Family
- 2) parents
- 3) post-training
- 4) models
- 5) pre-training
- 6) cues
- 7) consequences
- 8) instructional

Following the home visit the home visitor completes two copies of the Home Visit Report form and mails one copy in to the center.

91. A copy of the _____ form, which is completed following the home visit, is mailed to the center staff so that the early childhood special education specialist will have a record of what took place during the visit. The para-professional home visitor also maintains telephone contact with the Project Sunrise center by talking weekly with the center staff.

91. Home visit report

92. Once each _____ the home visitor is contacted by the center staff to discuss their home visits. The center staff is comprised of the coordinator, the early childhood special education specialists, the center aide, and the secretary.

92. week

93. The coordinator, the early childhood special education specialist, the _____, and the secretaries make up the center staff. Generally the home visitor will talk to a center aide who will help plan the next week's home visit.

93. center aide

94. The home visitor will plan the _____ for the next week with the help of the center aide. In addition, the center aide will ask for information about what occurred during the last home visit.

94. home visit

95. Information about what occurred during the _____ home visit will also be requested by the center aide during the weekly telephone conference. Another responsibility of the center aide is to assure that instructional materials for both parents and children are available to the paraprofessional home visitor.

95. last or previous

96. Instructional materials are checked in and out through the _____. Both the center aide and the home visitor work under the direction of the early childhood special education specialist.

96. center aide

97. The early childhood special education _____ are responsible for supervising the work of the center aides and home visitors. In addition they serve as the professional special educator responsible for assuring the planning and development of an appropriate educational program for young handicapped children.

97. specialist

98. The special educator who maintains the responsibility for appropriate services to young children with special needs is the _____. These staff members may be referred to as specialists or supervisors because of the different roles which they play.

98. early childhood
special education
specialist

99. Early childhood special education specialists are sometimes called _____ or _____ because of the responsibilities which they have in implementing the Project Sunrise model. As supervisors, they must be responsible for the training and performance of the center aides and home visitors.

99. specialists
supervisors

100. The training and _____ of the center aides and home visitors is the responsibility of the early childhood special education specialists in their role as supervisors. Consequently, the home visitors answer directly to their assigned supervisor.

100. performance

101. The person to whom a home visitor is directly responsible is their assigned _____. The supervisor is responsible for assuring parents that the home visitor is competent to work with parents and young children.

101. Supervisor

102. Before beginning to work with parents in their home, the supervisor must assure that the _____ is competent. To be competent means that the home visitor has adequate skills in order to work with parents and young children.

102. home visitor

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103. A home visitor must possess adequate _____

in order to work with parents and young children. When these skills have been acquired the home visitor is considered competent.

103. skills

104. To be considered _____

a home visitor must have acquired certain skills. To be certain that a home visitor is competent in the needed skills, the supervisor directly observes the home visitor using those skills.

104. competent

105. Direct _____ of the home visitor using

the needed skills is one means which the supervisor uses to assure that a home visitor is competent.

Such observations might take place in a role playing (pretend) situation or during an actual home visit to a family.

105. observation

106. Observation can take place during real home visits or

during _____ situations. Some-

times competency is determined by having the home visitor explain the steps in a procedure.

106. role playing

107. Explaining the steps in a _____ is

another way that the supervisor assures that the home visitor is competent. Sometimes competency is determined by having the home visitor record their thoughts or observations on paper.

107. procedure

108. Recording thoughts and recording _____ on

paper is another way that the supervisor assures that

a home visitor is competent. Competency of home visitors is checked in several ways including:

- 1) observation of role playing situations or actual home visits.
- 2) explanations of steps or procedures
- 3) written records of thoughts or observations

108. observations

109.

SUMMARY

The supervisors determine that a home visitor is competent. The home visitor must demonstrate that they possess certain skills when they

- 1) are directly _____ by the supervisor.
- 2) explain the _____ in a procedure, or when the home visitor prepares written records of
- 3) thoughts or _____.

109.

- 1) observed
- 2) steps
- 3) observations

The person who is ultimately responsible for assuring that the Project Sunrise model is properly implemented is the coordinator.

110.

The _____ of Project Sunrise is responsible for appropriate implementation of the model. This person is responsible for the administration of the grant and must be able to account for all budget expenditures.

110. coordinator

111. The coordinator has _____ responsibilities and must be able to justify all expenditures of grant money.

111. administrative

112.

SUMMARY

- 1) The preschool _____ with a handicap or "special need" is the target of Project Sunrise intervention.
- 2) The main focus of the home visit is the _____ who implement the lesson plans daily with the child.
- 3) The paraprofessional _____ makes weekly visits to the home to assist parents in becoming more effective teachers of their young child.
- 4) The _____ is the professionally trained educator who is responsible for developing an appropriate educational plan for the child and family and who instructs and supervises the work of the home visitors and center aides.
- 5) The _____ are responsible for providing the home visitors with needed instructional materials. They may also help the home visitor plan appropriate weekly lesson plan activities.
- 6) The _____ is responsible for the administration of the grant and ultimately is responsible for all details of implementing the Project Sunrise model

112.

1. child
2. parents
3. home visitor
4. early childhood specialist
5. center aides
6. coordinator

Name _____

Date _____

Understanding the Project Sunrise Model

Post Test

In the blank at the left write the letter corresponding to the answer that best completes each statement:

- ___ 1. Project Sunrise is a federally funded grant in the First Chance Network, officially known as:
 - a) The Bureau of Education for the Handicapped
 - b) The U.S. Office of Education
 - c) The Handicapped Children's Early Education Programs
 - d) The Department of Health, Education and Welfare.

- ___ 2. Project Sunrise can serve young children until their _____ birthday.
 - a) fourth
 - b) fifth
 - c) sixth
 - d) seventh

- ___ 3. In order to be considered eligible for Project Sunrise Services a child may meet any one of the following criteria except:
 - a) receive an abnormal or questionable rating on the Pre-school Profile.
 - b) receive an abnormal or questionable rating on the Denver Developmental Screening Test (DDST) or the Comprehensive Identification Process (CIP).
 - c) have a diagnosis of a handicapping condition by a doctor or an interdisciplinary diagnostic team.
 - d) a number of professionals involved with the family believe that the child may be at risk of requiring special education services during the school years.

- ___ 4. The Project Sunrise model is considered to be a _____ model.
 - a) home-based
 - b) center-based
 - c) combination center-home based
 - d) school preparatory

- ___ 5. The first step in providing services to a child is to check to see whether the child needs a more in-depth evaluation. This step is known as:
 - a) child find or identification
 - b) screening
 - c) assessment/evaluation
 - d) reassessment

- ___ 6. Sometimes a child's eligibility is determined when the _____ administers the Denver (DDST) to the child.
- a) parent
 - b) paraprofessional home visitor
 - c) center aide
 - d) early childhood special education specialist
- ___ 7. Permission to administer the assessment instruments to the child must be granted in writing by the parents prior to:
- a) referral
 - b) screening
 - c) administration of appropriate portions of the CAMS and UPAS
 - d) the interdisciplinary team evaluation
- ___ 8. One advantage of the home-based programs over center-based programs is that the home-based programs:
- a) permit teams of professionals to work with each child.
 - b) seem to help children maintain the cognitive gains which they make over longer periods of time
 - c) provide socialization experiences for parents.
 - d) provide socialization experiences for children.
- ___ 9. A _____ is someone with limited training who works with a professionally trained person.
- a) home visitor
 - b) center-aide
 - c) paraprofessional
 - d) early childhood special education specialist
- ___ 10. The Portage Project in Wisconsin found that:
- a) home visitors need to be in the home weekly
 - b) home visitors did not need to be in the home weekly
 - c) paraprofessional home visitors were as effective as professional home visitors.
 - d) paraprofessional home visitors were not as effective as professional home visitors.
- ___ 11. The purpose of the FEP is to help plan appropriate learning activities for:
- a) home visitors
 - b) center aides
 - c) parents
 - d) handicapped children

- ___ 12. That portion of the IEP which outlines the short-term objectives to be achieved by the child during a three month period is the:
- a) Family Education Program
 - b) Individualized Educational Plans
 - c) Individualized Instructional Plans
 - d) Home Visitor Training Needs Form
- ___ 13. Project Sunrise is considered a behavioral model because:
- a) it serves primarily children with behavior problems,
 - b) it teaches parents to use behavior modification in teaching their child.
 - c) it changes the behaviors of the child's brothers and sisters,
 - d) a child must exhibit unusual behaviors to be eligible.
- ___ 14. All of the following are considered part of the preschool child's curriculum except:
- a) reading skills
 - b) receptive and expressive language
 - c) self-help skills
 - d) gross and fine motor skills
- ___ 15. Skills in the self-help area refer to the child's ability to:
- a) solve problems with peers
 - b) interact appropriately with other adults
 - c) interact appropriately with siblings (brothers and sisters)
 - d) live independently
- ___ 16. The home visitor teaches the parents how to give their child appropriate _____ so the desired behavior will occur.
- a) cues
 - b) consequences
 - c) behaviors
 - d) data
- ___ 17. Those actions of the parents which follow the child's behavior and increase or decrease the likelihood of that behavior occurring in the future are known as:
- a) cues
 - b) consequences
 - c) behaviors
 - d) data
- ___ 18. The Home Observation for the Measurement of Environment (HOME) is used to help assess:
- a) child performance in the areas of language skills
 - b) child performance in the area of social-emotional skills
 - c) parent-child interaction
 - d) parent-sibling interaction

- ___ 19. Those people responsible for writing the child's Individualized Educational Plan comprise the:
- a) interdisciplinary diagnostic team
 - b) advisory board
 - c) board of directors
 - d) Child Study Team
- ___ 20. The paraprofessional home visitor is directly responsible to the:
- a) parents
 - b) center aides
 - c) early childhood special education specialists
 - d) coordinator

PROJECT SUNRISE

Home Visitor Orientation Training
Materials

Preschool Observation Packet

Experimental Version

December 1978

335

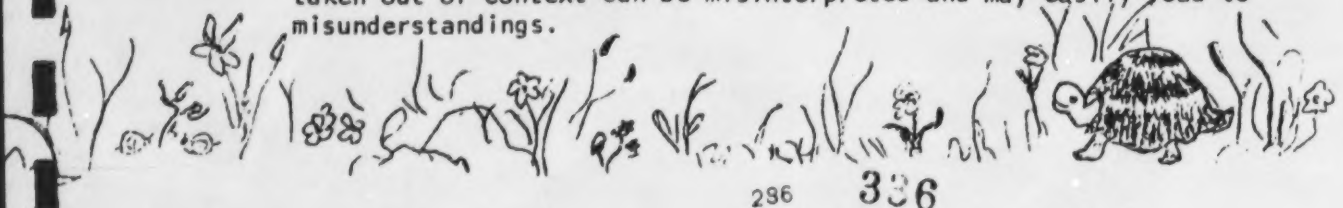
PRESCHOOL OBSERVATION

AS AN OBSERVER:

- 1) Remain as inconspicuous as possible while observing. If a child becomes aware that he has become the "center of attention", he will tend to behave somewhat differently than he would otherwise and the observer fails to see a true picture of behavior.
- 2) Look in another direction or otherwise ignore the child when a child is obviously attempting to attract attention from you.
- 3) Refrain from all unnecessary conversation while observing. Speak softly so that a child cannot hear you. Observation "centers" indoors and outdoors must be kept quiet in order for observers to hear conversations of children with teachers...and conversations of children with children.
- 4) Your cooperation in preventing accidents is needed. If a child is in immediate danger, the staff will welcome your assistance; i.e., if you see a child climbing without close supervision or handling a sharp object, etc., give any assistance needed, but discriminate between "needing to help a child out of danger" and adult interference.
- 5) Do not pick up the children or assist them in any manner unless a specific observer is asked to do so by a staff member. An exception: IN AN EMERGENCY, PLEASE HELP!
- 6) Do not try to amuse the children or to initiate conversation with them.
- 7) If a child should ask you a question, answer him accurately, courteously, and in a matter-of-fact manner.
- 8) Do not laugh or appear amused at anything a child says or does. He may continue his attempts to amuse you if he finds he has an audience. The emotional stimuli and responses will be supervised or initiated by the nursery school staff.
- 9) At all times avoid anything that will distract the child's concentration and his interest in play.

OBSERVERS' COMMENTS:

- 1) Be very cautious in commenting vocally on any child. These children are not to be discussed outside of class.
- 2) Your written observation reports are treated as confidential material in order to protect the children and their families. Some behavior taken out of context can be misinterpreted and may easily lead to misunderstandings.



PRESCHOOL OBSERVATION

Purpose: To increase trainee's awareness of normal developmental milestones in children birth through six through observations, activity planning and direct interaction with preschool children.

Conditions: Trainee will receive and read appropriate developmental information choosing one child of each appropriate age to observe each day in preschool, day care home or day care center.

Trainee will observe the 3 separate age groups (3's, 4's and 5's) for approximately 2 - 2½ hours on 3 different days.

Objective 1:

Conditions: Following the viewing of the video, "Early Learning: An Introduction to the Stages of Development in Infancy".

Trainee will: write or tape record answers to the discussion guide

As measured by: 12/15 correct answers to trainer's satisfaction

Objective 2:

Conditions: Following observation and reading of the provided developmental information

Trainee will: give 2 written examples of specific observed behaviors in each of 5 skill areas (self-help, pre-academic, social-emotional, motor and communication for each age group (3 years, 4 years and 5 years)

As measured by: trainer satisfaction

Objective 3:

Conditions: Following observation of one child each day in each age group

Trainee will: complete 3 A-B-C forms (one each day)

As measured by: at least 10 recorded "Antecedent-behavior-consequence" sequences

Objective 4:

Conditions: Following reading of the provided material on "Task Analysis"

Trainee will: task analyze 1 age appropriate activity for each age group (3 years, 4 years and 5 years)

As measured by: the analysis of each activity into at least 3 steps

PRESCHOOL OBSERVATION (cont'd)

Objective 5:

Conditions: Following implementation of 1 task-analyzed activity, with each of 3 children (a 3 year old, a 4 year old and a 5 year old)

Trainee will: record results on the appropriate pages in preschool observation materials

As measured by: trainer satisfaction

PRESCHOOL OBSERVATION

Approx.
Time Needed

Date Task Is
Completed

Before Day 1 at the center or school:

- 1) Observe the video, "Early Learning: An Introduction To the Stages of Development in Infancy". Write or tape record the answers to questions on page 45 Min.
- 2) Read developmental information on 3 year old children, including the 36-48 month level of the Preschool Profile. 15-30 Min.
- 3) Read information on task analysis on pages Complete exercises contained in that information. 15 Min.
- 4) Using activity suggestions in developmental information, choose and task analyze 1 appropriate activity for 3 year old children. Analyze the activity into at least 3 steps on the appropriate task analysis form on page 60 Min.
- 5) Read information on Antecedents-Behavior-Consequences, "The A-B-C's of Parent Child Interaction" on page 15 Min.

DAY 1: At Center or School

- 1) Choose one child who is 3 years of age to observe. Watch for and mark specific skills which are indicated in the 36-48 month level of the Preschool Profile. Mark (underline, precede with a check or circle) the skills which are noticeable in this 3 year old child with a green marker. 30 Min.
- 2) During or after observation, list 2 examples of specific observed behaviors in each of the 5 skill areas (motor, communication, pre-academic, social-emotional and self-help) on page 20 Min.
- 3) During observation of several incidents during the day, complete an A-B-C form on the specific child you are observing. Page 20 Min.
- 4) Implement the task you analyzed with the child you are observing. 30 Min.
- 5) Record the results of the activity on page 20 Min.



Before DAY 2 at the Center or School:

Approx.
Time Needed

Date Task Is
Completed

1) Read developmental information on 4 year old children, including the 48-60 month level of the Preschool Profile.

15-30' Min.

2) Review information on task analysis.

10 Min.

3) Using activity suggestions in developmental information, choose and task analyze 1 activity appropriate for 4 year old children. Analyze the activity into at least 3 steps on the appropriate task analysis form on page

60 Min.

4) Review "The A-B-C's of Parent-Child Interaction" on page

10' Min.



DAY 2: At Center or School:

1) Choose one child who is 4 years of age to observe. Watch for and mark specific skills which are indicated in the 48-60 month level of the Preschool Profile. Mark the skills noticeable in this 4 year old child with a yellow marker.

30' Min.

2) During or after observation, list 2 examples of specific observed behaviors in each of the 5 skill areas (motor, communication, pre-academic, social-emotional and self-help) on page

20' Min.

3) During observation of several incidents during the day, complete an A-B-C form on the specific child you are observing. Page

20' Min.

4) Implement task you analyzed with the child you are observing.

30 Min.

5) Record the results of the activity on page

20' Min.

Before DAY 3 at Center or School:

Approx.
Time Needed

Date Task Is
Completed

1) Read developmental information on 5 year old children, including the 60-72 month level of the Preschool Profile.

15-30 Min.

2) Review information on task analysis.

10 Min.

3) Using activity suggestions in developmental information, choose and task analyze 1 activity appropriate for 5 year old children. Analyze the activity into at least 3 steps on the appropriate task analysis form on page

60 Min.

4) Review "The A-B-C's of Parent-Child Interaction" on page

10 Min.

DAY 3: At School or Center:

1) Choose one child who is 5 years of age to observe. Watch for and mark specific skills which are indicated in the 60-72 month level of the Preschool Profile. Mark the skills noticeable in this 5 year old child with a red marker.

30 Min.

2) During or after observation, list 2 examples of specific observed behaviors in each of the 5 skill areas (motor, communication, pre-academic, social-emotional and self-help) on page

20 Min.

3) During observation of several incidents during the day, complete an A-B-C form on the specific child you are observing. Page

20 Min.

4) Implement the task you analyzed with the child you are observing.

30 Min.

5) Record the results of the activity on page

20 Min.



THE ABC'S OF PARENT-CHILD INTERACTION

THE ABC'S OF PARENT-CHILD INTERACTION

The interactions that typically occur between parents and children are many-faceted and complex. One could easily become lost in the maze of attempting to account for these interactions, without adhering to a given theoretical framework. Even when one does adopt a particular point of reference, the subtlety and nuance of parent-child interactions remain a source of amazement and challenge. However, by viewing interactions through the eyes of the adopted framework, one can begin to approximate a systematic test of the clinical and perhaps empirical limits of that framework, gradually gathering information and recommendations for practitioners.

The *Portage Parent Program* adheres to a social learning perspective in conceptualizing the establishment and maintenance of parent-child interactions. The focus is further narrowed by an attempt to limit the perspective to the interactions centered around the teaching and child management domains. Thus, no systematic attempt is made to include other significant domains such as the affective or communication areas, although aspects of each are discussed as they relate to either the teaching or the child management domain.

Social learning theory simply states that most human behavior is determined by environmental forces. The environment, particularly the child's social environment, shapes and maintains most of the child's behavioral repertoire. When analyzing parent-child interactions in the teaching and child management domains, then, it is assumed that the crucial elements controlling the child's behavior are the parental antecedent and consequent events (i.e., those parent behaviors which precede or follow the child's response). For example, the parent's behavior may serve as a significant model (antecedent event) for the child. If the child then imitates this behavior and is reinforced by the parent (consequent event), the probability that the behavior will be repeated is increased. This Antecedent-Behavior-Consequent paradigm has proven quite useful in terms of analyzing parent-child interactions and in implementing strategies to either decelerate maladaptive behavior or accelerate adaptive behavior. The role and responsibility of the parent in shaping and maintaining child behavior is obviously highlighted. Relatively little attention is given to the opposite phenomenon where the child's behavior is seen as influencing the parent's behavior, which has recently become the focus of some empirical study. Despite the possible controlling effects of child behavior on parent behavior, the opposite directionality is taken in the *Portage Parent Program* because of the greater ease in rearranging parental antecedent and consequent behavior to change child response.

By emphasizing the amount of control the parent actually does have over the child's behavior (whether adaptive or maladaptive) the potential for constructive change is heightened in the parent's mind. Too often we see parents throw up their hands in frustration when confronted with certain child behaviors, disclaiming any control over the situation. By putting the child's behavior back into the context of

the parental antecedent and consequent events, we can demonstrate to parents the potential they have to begin to positively affect the behavior and development of their children. Care must be taken, however, to stress a sense of hope and optimism as some parents may dwell on the negative aspects of their role in the current behavior exhibited by their child. We do not intend to merely take a negative, retrospective view of the controlling effects of parent behavior on child behavior, and thus perhaps inadvertently induce guilt in the parent. Our intent is to realistically appraise the current situation, and then emphasize the positive change that can occur if the parent engages in more appropriate antecedent and consequent responses.

Practitioners must not, then, isolate child response as existing separate from environmental forces. The Antecedent-Behavior-Consequent model helps instructors and parents view child behavior as part of an interactional process between the child and his social environment, particularly the parents, rather than isolating child behavior as a phenomenon divorced from parental behavior. Questions to be asked when analyzing the events controlling child response are:

- 1) What events immediately precede the child behavior? (Antecedents)
- 2) What events immediately follow the child behavior? (Consequents)
- 3) What antecedent or consequent events could be rearranged to produce more desirable child response?

Instructors must not only ask themselves these important questions, but they must also ask them of the parents in order to model appropriate problem solving strategies so that hopefully the parent will begin to assume this responsibility. By cooperatively analyzing situations and devising strategies to facilitate child development, the instructor can gradually shift the control to the parent by progressing through modeling - cueing - consulting phases.

It may be helpful to construct a schematic representation of the parent-child interaction in order to isolate the controlling events and devise strategies for change. The following is a schematic representation of an appropriate teaching interaction:

Antecedent

Parental Model: "Johnny this is a square. Can you say 'square'?"

Behavior

Child Response: "Square"

Consequent

Parental Reinforcement: "Good job!"

In this interaction the parent is providing an initial model to aid the child in producing the correct response, thus allowing the child to experience success. The parent additionally provided a social reinforcer to consequence the child's correct

response, thus increasing the probability the child will repeat this response. After a number of correct trials, the parent may eliminate the model and simply give the command, "This is a _____" or provide limited aid in the form of the initial consonant sound, "This is a sq...", in order to evoke correct response.

The A-B-C paradigm can be used equally well to represent inappropriate parental antecedent and consequent events which serve to evoke and maintain child misbehavior. For example, one parent was noted to rarely give any kind of aid to initiate a teaching situation with her child. The typical interaction started with the parent giving a command. The child could not respond correctly as the task was new to her, and she therefore would either respond incorrectly or balk at making any response whatsoever due to experiencing repeated failure. The potential affective and behavioral consequences of this pattern of interaction are obvious. The entire interaction between the parent and child during teaching sessions was becoming quite negative, making the situation aversive to both of them, particularly as the parent would consequate the child's behavior with various negative statements. Schematically, this interaction was as follows:

Antecedent

Parental command without aid: "Suzie, show me the yellow one."

Behavior

Child Response: "No, I don't want to."

Consequent

Parental Negative Statement: "Now stop that nonsense and show me the yellow one."

The instructor quickly isolated the controlling effects of the parent's antecedent behavior on the child's responses, demonstrated this schematically with the parent, and then devised strategies for change. Providing a model to initiate a task, and giving other forms of instructional aid to help the child acquire the skill, were the specific parental antecedent events targeted for intervention. A rationale and descriptive discussion regarding these techniques took place between the parent and the instructor. The instructor then modeled these behaviors for the parent, and later had the parent model these responses, with the instructor providing corrective or reinforcing feedback. The parent was then able to practice these skills under the supervision of the instructor, gradually incorporating these more facilitative responses into her teaching repertoire. Changing the parental antecedent behaviors enabled the child to respond correctly which resulted in change in parental consequent events as well. The parent was able to provide reinforcement to the child for correct response and thus avoided making negative statements. The interaction between the parent and child improved considerably not only during the formal teaching sessions, but also during their more informal contacts. An additional outcome was an increased rate of learning by the child.

An instance of a parental consequent event which precipitated inappropriate child response was noted in another parent who was in the habit of giving negative feedback whenever the child made an incorrect response.

Sometimes the parent would also give corrective feedback, but even when she provided a correction it was always preceded by the negative statement. The negative feedback included statements such as:

- a) "No, that's not right!"
- b) "That's not the one."
- c) "No, that one is yellow."
- d) "No, that one is a circle. Here's the square."

The effect of these negative statements was to evoke child misbehavior in the form of whining, crying, and refusal to work at the task any longer. The parent would then either attempt to coax further work out of the child, or she would abruptly end the teaching session: "OK, if you're not going to cooperate, then we'll just quit." Thus, the child was reinforced for her whining and crying by either receiving undue attention in the form of parental coaxing, or through having the session terminated by the parent. This entire chain of events demonstrates how the consequent for one child response can serve as the antecedent event for the next child behavior. The interactions between parents and children consist of these chains of behavior and it is only when we need to isolate the controlling effects of parent behavior on child response do we need to somewhat artificially break them out into the A-B-C model. A schematic representation of the above interaction would be:

Antecedent	Behavior	Consequent
Parental Command: "Tracy, point to the lion."	Child points to the picture of the bear.	Parental negative Statement: "No, that's not right, now point to the lion."
	Child starts to whine and shake her head.	"OK, then we'll just stop."

In this case, the objective agreed upon by the parent and the instructor was to have the parent eliminate the use of negative statements following any incorrect response on the part of the child, and substitute giving only the necessary corrective feedback. Subsequent sessions indicated a gradual decrease in the percentage of time the parent gave a negative statement as a response to incorrect performance of her child. Interestingly, a corresponding decrease in child misbehavior was also noted. After four or five weeks of this trend, a sudden and sharp increase in parental negative statements was observed, and the percentage of child misbehavior mirrored the parent's behavior. The instructor and the parent again reviewed this phenomenon and rehearsed providing corrective feedback without pairing it with a negative statement. The following week, a low incidence of both parental negative statements following incorrect child response and child misbehavior was demonstrated. The parent had learned her lesson well. By being able to see the controlling effects of her negative statements on her child's misbehavior, especially the correspondence between increases and decreases in each, this parent was given a most convincing demonstration that enabled her to change her behavior and maintain more appropriate reactions to her child's incorrect response.

The above situations exemplify the utility of the Antecedent-Behavior-Consequent paradigm in the analysis of parent-child interaction and in devising strategies for change. The model is reflected throughout each component of the Parent Program, including the *Parental Behavior Inventory* to be

discussed in the next section. This inventory helps instructors identify and target for change specific parental antecedent and consequent behaviors which may be controlling child response or which could be modified to further the child's development.

NAME: John Doe

TIME: 9:00 - 9:15

DATE: 1-8-78

OBSERVER: Diane Smith

SETTING: Happy Day Care Center

[illegible]

TASK ANALYSIS

Task analysis refers to choosing a terminal or long-term teaching objective and breaking that goal into several sequential smaller steps or target behaviors. These target behaviors are tailored to meet the individual learning characteristics of a particular child. A terminal objective for the child is determined based upon his present skill level. For example, a terminal objective for a child who can match colors, but is unable to name any might be to teach the child to name two colors upon request. Depending upon the child's rate of learning and his present skill level, this goal may take a considerable amount of time to accomplish. To assure that the child is successful, you would break the task down into a series of smaller, sequential steps which the child could achieve in a shorter time.

This procedure aids in specifying the behavior you wish to teach and provides a step-by-step progression for the child in attaining the desired terminal behavior.

An example of task analysis of naming "nose" follows:

TERMINAL BEHAVIOR: Will name "nose".

PRESENT BEHAVIOR: Points to his nose when asked "where is your nose?"

1. Will point to nose of another person.
2. Will point to nose on a picture of a face.
3. Will repeat "nose" in imitation when you point to his nose and say,
"What is this?"
4. Will say "nose" with initial sound cue when you point to his nose and say,
"What is this?"
5. Will say "nose" when you point to his nose and say, "What is this?"

Task Analysis
Page 2

This is only an example of the progression one might use to teach this behavior. There are other ways also. The target behaviors you choose will be dependent upon the particular child's present skill level and his style of learning. It may be necessary to break the task into smaller steps for the child to achieve success; or it is possible that the child will reach the terminal objective without individual teaching of each subskill.

The process of task analysis often involves changing the condition under which the behavior occurs. Three types of conditions or aid are physical, visual, and verbal. The following example shows how by changing the conditions, the task becomes progressively more difficult and closer to the terminal goal.

TERMINAL BEHAVIOR: Jane will draw a square upon request.

PRESENT BEHAVIOR: Jane can grasp a crayon and draw a circle.

- | | |
|------------|---|
| Physical | 1. Jane will trace over a square with mother guiding her hand. |
| Visual | 2. Jane will connect dashes to complete square. |
| Visual | 3. Jane will copy a square. |
| Verbal | 4. Jane will draw a square with verbal cues, "across-down-over-up". |
| on Request | 5. Jane will draw a square upon request. |

COMPLETE A TASK ANALYSIS

Terminal Behavior: Will drink four ounces of fluid from a cup without spilling.

Present Behavior: Drinks from cup when adult holds and directs cup.

1. _____
2. _____
3. _____
4. _____
5. _____

TERMINAL BEHAVIOR: Sara will hop forward five consecutive times without aid.

PRESENT SKILL LEVEL: Sara can stand on one foot for three seconds when holding her mother's hand.

1. _____
2. _____
3. _____
4. _____
5. _____

Portage Project Training Materials
Cooperative Educational Service Agency #12
Box 564
Portage, WI 53901

TASK ANALYSIS FORM

Child Lori Home Visitor Allan
Date 2/21/79 Materials to be used in task one wooden or plastic
bead, string
Setting Henry Bear Inst.

Complete a Task Analysis (analyze into at least 3 successive steps):

Terminal Behavior: will String 3 large beads.

1. Holding bead in one hand and string in other Lori, will push string
through hole.
2. With fingers not covering the hole, Lori will grasp end of string and
pull it through the hole.
3. Child will let bead drop down on string
4. Lori will string three beads without assistance.
5.

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Child Dana

Date 2/19-79

Home Visitor Allan

Setting Honey Bear Institute

RESULTS OF ACTIVITIES IMPLEMENTED WITH CHILDREN

Activity Teaching Dana to string beads, at least 3 without assistance.

Was child able to complete specified criteria for activity? Why or why not? Dana was tired during this activity but tried diligently for first 10 minutes that we worked together. Several times he repeated "I can't".

What would you do differently if you were trying this activity again with the same child? Yes, although Dana needs more work in the area of fine motor skills (he had difficulty pulling the string through the hole and grasping it before it snapped back through the hole.) He was able to string five beads before losing patience and interest. I would give more reinforcement each time he accomplished the stringing of a bead. I would encourage him to push more of the string in the hole before trying to grasp it.

CHARACTERISTIC BEHAVIORS

Home Visitor _____ Setting _____

Skill Area

Age of Child	Motor	Communication	Pre-Academic	Social-Emotional	Self-Help
Child: _____ 3 yrs. Date: _____	1) 1st behavior: 2) 2nd behavior:	1) 2)	1) 2)	1) 2)	
Child: _____ 4 yrs. Date: _____	1) 1st behavior: 2) 2nd behavior:	1) 2)	1) 2)	1) 2)	301
Child: _____ 5 yrs. Date: _____	1) 1st behavior: 2) 2nd behavior:	1) 2)	1) 2)	1) 2)	351 352

Film Discussion Guide

EARLY LEARNING: AN INTRODUCTION TO THE STAGES OF DEVELOPMENT IN INFANCY

Jean Piaget learned how children's thinking develops by watching the behavior of his own children. As a result of years of study talking to children, listening to children, and watching children solve problems, he developed a system of placing child behaviors into specific steps. These steps he called "stages" and he observed that all children pass through these various steps, although not always at the same age. Each step is a building block for a later one, and the child must go through the earlier steps before he is able to move on to the more complex stages. The stages of infancy are as follows:

Touch, Look & Listen (0-1 month)

Babies are born with many ways to explore the world. They discover things by looking, listening and touching. At first babies can only respond with reflex actions (crying, moving, sucking, looking). But soon babies are able to coordinate these movements (looking with touching, touching with grasping) and get hold of what they see.

1. What are babies' main interests at this early age?
2. What are some of the ways that a baby lets us know about her/his needs and wants?

If At First You Don't Succeed (1-4 months)

During this time the baby is becoming increasingly more interested in the surroundings and begins to actively use toys and objects. It is during this stage that the infant develops the ability to grasp objects

and hold on to them purposefully. Once the infant is able to hold the object there are many things she/he is able to do with it: bang it, shake it, put it in her/his mouth, and drop it. She/he will delight in repeating these actions.

1. How do the skills developed in this stage build on what the infant was able to accomplish earlier?
2. What can adults do to facilitate the learning at this stage?

Infant Power (4-8 months)

As the infant acquires more skill in handling objects, he/she becomes increasingly interested in what he/she can do with them. Through accidental discoveries with objects, the infant begins to explore the many different things he/she can do with the objects (i.e. shaking a rattle, squeezing a squeaker toy, taking apart and putting together objects).

1. What kinds of things can we do to encourage babies to learn new things?
2. What types of toys and materials are the most interesting to babies at this stage?

Getting It All Together (8-12 months)

Objects become more interesting to the infant now as he/she is able to do more with them. The infant becomes curious about all sorts of things (i.e., what causes objects to move, where an object or person goes when they disappear). During this time imitation becomes important to the infant, as he enjoys trying to imitate sounds and actions of others.

1. In the hiding games, what steps did the baby have to go through to learn how to find things?
2. How did the mother help the baby get used to the puppet?
How did the baby react to the puppet?
3. What is the value of playing "talking" games with children?

Try It, You'll Like It (12-18 months)

The infant is now delighted with his/her new skills and discoveries. She/he is interested in trying out everything. She/he actively explores all objects and discovers new ways to use old materials.

1. How do you suppose the toddler knew the round puzzle piece would roll and the square one wouldn't?
2. Did Antoine use the blocks differently than a six month old would?

Explain.

3. Do toddlers gain pleasure from their accomplishments?
How do you know?

Thinking and Remembering - The Mad Scientist (18-24 months)

Now the toddler begins to anticipate actions, think about cause and effect and predict the outcomes of his actions. He can solve small problems, and can call on past experiences to help. Language becomes important, as the toddler now attempts to communicate his thoughts to adults.

1. What did Jenny learn about the stacking rings?
Cup sizes?
2. What other experiences require "thinking and remembering?"
3. What activities can help increase problem solving and
language skills at this age?

NOTES:

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PROJECT SUNPISE
Tentative Agenda
PRE-SERVICE HOME VISITOR TRAINING WORKSHOP
Day One

- 9:00 - 9:30 - Coffee and goodies
- 9:30 - 10:00 - Getting to know you
- 10:00 - 10:45 - A little quiz on the Programmed Text
- 10:45 - 12:00 - Denver Developmental Screening Test (DDST) Introduction
- 12:00 - 1:30 - Lunch (downtown)
- 1:30 - 2:00 - Practice scoring DDST from film
- 2:00 - 2:30 - Practicum for DDST (real, live children!)
- 2:30 - 3:00 - Denver Articulation Screening Test (DAST)
and Denver Screening Test (DEST) Introduction
- 3:00 - 3:15 - Break
- 3:15 - 4:00 - Practice scoring DASE and DEST
- 4:00 - 4:30 - Conditions of risk to the young child
- 4:30 - 5:00 - Review
- 5:00 - 7:00 - Dinner - You're on your own.
- 7:00 - 7:45 - The grieving process faced by families of handicapped children.
- 7:45 - 8:30 - Discussion and sharing with family members
- 8:30 - 9:00 - Wrap up

DAY TWO

- 8:00 - 8:30 - Coffee and goodies
- 8:30 - 9:15 - What is the relationship between screening, assessment, evaluation, and instructional activities?
- 9:15 - 10:00 - Administering the Communication and preacademic assessments (UPAS)
- 10:00 - 10:15 - Break
- 10:15 - 11:00 - Observe administration of communication and preacademic assessments
- 11:00 - 12:00 - Practicum - Administering UPAS
- 12:00 - 1:00 - Lunch - about the gourmet fare at the SUB?
- 1:00 - 2:00 - Administering the CAMS assessment
- 2:00 - 2:15 - Break
- 2:15 - 3:00 - Practice scoring CAMS assessment
- 3:00 - 3:30 - Top Notch interviewing
- 3:30 - 4:30 - The Home Observation for the Measurement of the Environment (HOME)
- 4:30 - 5:00 - Practice scoring the HOME
- 5:00 - 5:30 - Results of HOME

DAY THREE

- 8:00 - 8:30 - Coffee and goodies
- 8:30 - 9:45 - Behavior Management
- 9:45 - 10:00 - Break
- 10:00 - 10:45 - Problem solving behavior problems
- 10:45 - 11:15 - Identifying Parental cues and consequences
- 11:15 - 12:00 - Review Behavior Modification
- 12:00 - 1:00 - More sub fare?
- 1:00 - 3:30 - Role playing the home visit
- 3:00 - 3:30 - Workshop evaluations

Self evaluations

In-service training assignments

Head Home to recover!

Home-Visitor Inservice Training
Schedule

Track 1	Track 2
Trainees assigned to serve a family*	Trainees without a family assignment.
Week 1 1. Supervisor meets with trainee to discuss objectives and plans for home visit. 2. Trainee observes supervisor conducting home visit. 3. Follow-up staff meeting between supervisor and home visitor. a. Jointly complete home visit report. b. Assign one part of next home visit to trainee. c. Make training assignments relative to needed competencies Week 2 1. Supervisor meets with trainee to discuss objectives and plans for home visit. 2. Trainee observes supervisor conducting home visit. 3. Follow-up staff meeting between supervisor and home visitor. a. Jointly complete home visit report. b. Assign one part of next home visit to trainee. c. Make training assignments relative to needed competencies.	Week 1 1. Practice administration of DDST DASE, and DEST with at least two children. 2. In a joint session with the supervisor, administer and score the DDST, DASE and DEST. Week 2 1. Practice administration of two sections of the child assessment procedure. 2. In a joint session with the supervisor, administer and score the two sections of the child assessment procedure. Week 3 Repeat 1 and 2 under week 2. Week 4 Repeat 1 and 2 under week 2 Week 5 1. Practice administering the HOME with at least two families. 2. In a joint session with the supervisor, score the HOME.

Home-Visitor Inservice Training
Schedule

Track 1	Track 2
Trainee assigned to serve a family*	Trainee without a family assignment.
2. Trainee conducts assigned parts of home visit. 3. Follow-up staff meeting a. Trainee completes Home visit report. b. Discuss trainees strengths and needs relative to the home visit. c. Plan next home visit to be conducted by the trainee with supervisor present. d. Make additional training assignments. Week 3 1. Supervisor meets with trainee to discuss objectives and plans for home visit. 2. Supervisor observes trainee conducting home visit and completes a Home Visitor Supervisor report. 3. Follow-up staff meeting a. Discuss trainee's strengths and needs relative to the home visit. b. Plan next home visit to be conducted by the trainee alone. c. Make additional training assignments.	

Home-Visitor Inservice Training
Schedule

Track 1	Track 2
Trainees assigned to serve a family.*	Trainees without a family assignment.
Week 4 1. Trainee conducts home visit alone. 2. Supervisor holds telephone conference with trainee relative to home visit. Week 5 1. Supervisor again observes the trainee conducting the home visit and completes a Home Visitor Supervisor Report. Week 6 1 Trainee conducts home visit. 2. Center aides or supervisor holds telephone conference with trainee.	

*Assignments may take more than one week for the trainee to reach criteria on the competency.